



Rep. Bob Morgan

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LRB102 22845 BMS 36205 a

1 AMENDMENT TO HOUSE BILL 4493

2 AMENDMENT NO. _____. Amend House Bill 4493 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Motor Vehicle Theft Prevention
5 and Insurance Verification Act is amended by changing Sections
6 8.5 and 8.6 as follows:

7 (20 ILCS 4005/8.5)

8 (Section scheduled to be repealed on January 1, 2025)

9 Sec. 8.5. State Police Motor Vehicle Theft Prevention
10 Trust Fund. The State Police Motor Vehicle Theft Prevention
11 Trust Fund is created as a trust fund in the State treasury.
12 The State Treasurer shall be the custodian of the ~~Trust~~ Fund.
13 The State Police Motor Vehicle Theft Prevention Trust Fund is
14 established to receive funds from the Illinois Motor Vehicle
15 Theft Prevention and Insurance Verification Council. All
16 interest earned from the investment or deposit of moneys

1 accumulated in the ~~Trust~~ Fund shall be deposited into the
2 ~~Trust~~ Fund. Moneys in the ~~Trust~~ Fund shall be used by the
3 Illinois State Police for motor vehicle theft prevention
4 purposes.

5 (Source: P.A. 102-538, eff. 8-20-21.)

6 (20 ILCS 4005/8.6)

7 Sec. 8.6. State Police Training and Academy Fund; Law
8 Enforcement Training Fund. Before April 1 of each year, each
9 insurer engaged in writing private passenger motor vehicle
10 insurance coverage that is included in Class 2 and Class 3 of
11 Section 4 of the Illinois Insurance Code, as a condition of its
12 authority to transact business in this State, may collect and
13 shall pay ~~shall collect and remit~~ to the Department of
14 Insurance an amount equal to \$4, or a lesser amount determined
15 by the Illinois Law Enforcement Training Board by rule,
16 multiplied by the insurer's total earned car years of private
17 passenger motor vehicle insurance policies providing physical
18 damage insurance coverage written in this State during the
19 preceding calendar year. Of the amounts collected under this
20 Section, the Department of Insurance shall deposit 10% into
21 the State Police Training and Academy Fund and 90% into the Law
22 Enforcement Training Fund.

23 (Source: P.A. 102-16, eff. 6-17-21.)

24 Section 10. The Illinois Insurance Code is amended by

1 changing Sections 35B-30, 143, 143a, 229.4a, 353a, 355a, 408,
2 412, and 416 and by adding Section 355c as follows:

3 (215 ILCS 5/35B-30)

4 Sec. 35B-30. Certificate of division.

5 (a) After a plan of division has been adopted and
6 approved, an officer or duly authorized representative of the
7 dividing company shall sign a certificate of division.

8 (b) The certificate of division shall set forth:

9 (1) the name of the dividing company;

10 (2) a statement disclosing whether the dividing
11 company will survive the division;

12 (3) the name of each new company that will be created
13 by the division;

14 (4) the kinds of insurance business enumerated in
15 Section 4 that the new company will be authorized to
16 conduct;

17 (5) the date that the division is to be effective,
18 which shall not be more than 90 days after the dividing
19 company has filed the certificate of division with the
20 recorder, with a concurrent copy to the Director;

21 (6) a statement that the division was approved by the
22 Director in accordance with Section 35B-25;

23 (7) ~~(6)~~ a statement that the dividing company
24 provided, no later than 10 business days after the
25 dividing company filed the plan of division with the

1 Director, reasonable notice to each reinsurer that is
2 party to a reinsurance contract that is applicable to the
3 policies included in the plan of division;

4 (8) ~~(7)~~ if the dividing company will survive the
5 division, an amendment to its articles of incorporation or
6 bylaws approved as part of the plan of division;

7 (9) ~~(8)~~ for each new company created by the division,
8 its articles of incorporation and bylaws, provided that
9 the articles of incorporation and bylaws need not state
10 the name or address of an incorporator; and

11 (10) ~~(9)~~ a reasonable description of the capital,
12 surplus, other assets and liabilities, including policy
13 liabilities, of the dividing company that are to be
14 allocated to each resulting company.

15 (c) The articles of incorporation and bylaws of each new
16 company must satisfy the requirements of the laws of this
17 State, provided that the documents need not be signed or
18 include a provision that need not be included in a restatement
19 of the document.

20 (d) A certificate of division is effective when filed with
21 the recorder, with a concurrent copy to the Director, as
22 provided in this Section or on another date specified in the
23 plan of division, whichever is later, provided that a
24 certificate of division shall become effective not more than
25 90 days after it is filed with the recorder. A division is
26 effective when the relevant certificate of division is

1 effective.

2 (Source: P.A. 100-1118, eff. 11-27-18.)

3 (215 ILCS 5/143) (from Ch. 73, par. 755)

4 Sec. 143. Policy forms.

5 (1) Life, accident and health. No company transacting the
6 kind or kinds of business enumerated in Classes 1 (a), 1 (b)
7 and 2 (a) of Section 4 shall issue or deliver in this State a
8 policy or certificate of insurance or evidence of coverage,
9 attach an endorsement or rider thereto, incorporate by
10 reference bylaws or other matter therein or use an application
11 blank in this State until the form and content of such policy,
12 certificate, evidence of coverage, endorsement, rider, bylaw
13 or other matter incorporated by reference or application blank
14 has been filed electronically with the Director, either
15 through the System for Electronic Rate and Form Filing (SERFF)
16 or as otherwise prescribed by the Director, and approved by
17 the Director. Any such endorsement or rider that unilaterally
18 reduces benefits and is to be attached to a policy subsequent
19 to the date the policy is issued must be filed with, reviewed,
20 and formally approved by the Director prior to the date it is
21 attached to a policy issued or delivered in this State. It
22 shall be the duty of the Director to disapprove or withdraw
23 ~~withhold approval of~~ any such policy, certificate,
24 endorsement, rider, bylaw or other matter incorporated by
25 reference or application blank filed ~~with him~~ if it contains

1 deficiencies, provisions which encourage misrepresentation or
2 are unjust, unfair, inequitable, ambiguous, misleading,
3 inconsistent, deceptive, contrary to law or to the public
4 policy of this State, or contains exceptions and conditions
5 that unreasonably or deceptively affect the risk purported to
6 be assumed in the general coverage of the policy. In all cases
7 the Director shall approve, withdraw, or disapprove any such
8 form within 60 days after submission unless the Director
9 extends by not more than an additional 30 days the period
10 within which ~~the he shall approve or disapprove any such~~ form
11 shall be approved, withdrawn, or disapproved by giving written
12 notice to the insurer of such extension before expiration of
13 the initial 60 days period. The Director shall withdraw ~~his~~
14 approval of a policy, certificate, evidence of coverage,
15 endorsement, rider, bylaw, or other matter incorporated by
16 reference or application blank if it is subsequently
17 determined ~~he subsequently determines~~ that such policy,
18 certificate, evidence of coverage, endorsement, rider, bylaw,
19 other matter, or application blank is misrepresentative,
20 unjust, unfair, inequitable, ambiguous, misleading,
21 inconsistent, deceptive, contrary to law or public policy of
22 this State, or contains exceptions or conditions which
23 unreasonably or deceptively affect the risk purported to be
24 assumed in the general coverage of the policy or evidence of
25 coverage.

26 If a previously approved policy, certificate, evidence of

1 coverage, endorsement, rider, bylaw or other matter
2 incorporated by reference or application blank is withdrawn
3 for use, the Director shall serve upon the company an order of
4 withdrawal of use, either personally or by mail, and if by
5 mail, such service shall be completed if such notice be
6 deposited in the post office, postage prepaid, addressed to
7 the company's last known address specified in the records of
8 the Department of Insurance. The order of withdrawal of use
9 shall take effect 30 days from the date of mailing but shall be
10 stayed if within the 30-day period a written request for
11 hearing is filed with the Director. Such hearing shall be held
12 at such time and place as designated in the order given by the
13 Director. The hearing may be held either in the City of
14 Springfield, the City of Chicago or in the county where the
15 principal business address of the company is located. The
16 action of the Director in disapproving or withdrawing such
17 form shall be subject to judicial review under the
18 Administrative Review Law.

19 This subsection shall not apply to riders or endorsements
20 issued or made at the request of the individual policyholder
21 relating to the manner of distribution of benefits or to the
22 reservation of rights and benefits under his life insurance
23 policy.

24 (2) Casualty, fire, and marine. The Director shall require
25 the filing of all policy forms issued or delivered by any
26 company transacting the kind or kinds of business enumerated

1 in Classes 2 (except Class 2 (a)) and 3 of Section 4 in an
2 electronic format either through the System for Electronic
3 Rate and Form Filing (SERFF) or as otherwise prescribed and
4 approved by the Director. In addition, he may require the
5 filing of any generally used riders, endorsements,
6 certificates, application blanks, and other matter
7 incorporated by reference in any such policy or contract of
8 insurance. Companies that are members of an organization,
9 bureau, or association may have the same filed for them by the
10 organization, bureau, or association. If the Director shall
11 find from an examination of any such policy form, rider,
12 endorsement, certificate, application blank, or other matter
13 incorporated by reference in any such policy so filed that it
14 (i) violates any provision of this Code, (ii) contains
15 inconsistent, ambiguous, or misleading clauses, or (iii)
16 contains exceptions and conditions that will unreasonably or
17 deceptively affect the risks that are purported to be assumed
18 by the policy, he shall order the company or companies issuing
19 these forms to discontinue their use. Nothing in this
20 subsection shall require a company transacting the kind or
21 kinds of business enumerated in Classes 2 (except Class 2 (a))
22 and 3 of Section 4 to obtain approval of these forms before
23 they are issued nor in any way affect the legality of any
24 policy that has been issued and found to be in conflict with
25 this subsection, but such policies shall be subject to the
26 provisions of Section 442.

1 (3) This Section shall not apply (i) to surety contracts
2 or fidelity bonds, (ii) to policies issued to an industrial
3 insured as defined in Section 121-2.08 except for workers'
4 compensation policies, nor (iii) to riders or endorsements
5 prepared to meet special, unusual, peculiar, or extraordinary
6 conditions applying to an individual risk.

7 (Source: P.A. 97-486, eff. 1-1-12; 98-226, eff. 1-1-14.)

8 (215 ILCS 5/143a) (from Ch. 73, par. 755a)

9 Sec. 143a. Uninsured and hit and run motor vehicle
10 coverage.

11 (1) No policy insuring against loss resulting from
12 liability imposed by law for bodily injury or death suffered
13 by any person arising out of the ownership, maintenance or use
14 of a motor vehicle that is designed for use on public highways
15 and that is either required to be registered in this State or
16 is principally garaged in this State shall be renewed,
17 delivered, or issued for delivery in this State unless
18 coverage is provided therein or supplemental thereto, in
19 limits for bodily injury or death set forth in Section 7-203 of
20 the Illinois Vehicle Code for the protection of persons
21 insured thereunder who are legally entitled to recover damages
22 from owners or operators of uninsured motor vehicles and
23 hit-and-run motor vehicles because of bodily injury, sickness
24 or disease, including death, resulting therefrom. Uninsured
25 motor vehicle coverage does not apply to bodily injury,

1 sickness, disease, or death resulting therefrom, of an insured
2 while occupying a motor vehicle owned by, or furnished or
3 available for the regular use of the insured, a resident
4 spouse or resident relative, if that motor vehicle is not
5 described in the policy under which a claim is made or is not a
6 newly acquired or replacement motor vehicle covered under the
7 terms of the policy. The limits for any coverage for any
8 vehicle under the policy may not be aggregated with the limits
9 for any similar coverage, whether provided by the same insurer
10 or another insurer, applying to other motor vehicles, for
11 purposes of determining the total limit of insurance coverage
12 available for bodily injury or death suffered by a person in
13 any one accident. No policy shall be renewed, delivered, or
14 issued for delivery in this State unless it is provided
15 therein that any dispute with respect to the coverage and the
16 amount of damages shall be submitted for arbitration to the
17 American Arbitration Association and be subject to its rules
18 for the conduct of arbitration hearings as to all matters
19 except medical opinions. As to medical opinions, if the amount
20 of damages being sought is equal to or less than the amount
21 provided for in Section 7-203 of the Illinois Vehicle Code,
22 then the current American Arbitration Association Rules shall
23 apply. If the amount being sought in an American Arbitration
24 Association case exceeds that amount as set forth in Section
25 7-203 of the Illinois Vehicle Code, then the Rules of Evidence
26 that apply in the circuit court for placing medical opinions

1 into evidence shall govern. Alternatively, disputes with
2 respect to damages and the coverage shall be determined in the
3 following manner: Upon the insured requesting arbitration,
4 each party to the dispute shall select an arbitrator and the 2
5 arbitrators so named shall select a third arbitrator. If such
6 arbitrators are not selected within 45 days from such request,
7 either party may request that the arbitration be submitted to
8 the American Arbitration Association. Any decision made by the
9 arbitrators shall be binding for the amount of damages not
10 exceeding \$75,000 for bodily injury to or death of any one
11 person, \$150,000 for bodily injury to or death of 2 or more
12 persons in any one motor vehicle accident, or the
13 corresponding policy limits for bodily injury or death,
14 whichever is less. All 3-person arbitration cases proceeding
15 in accordance with any uninsured motorist coverage conducted
16 in this State in which the claimant is only seeking monetary
17 damages up to the limits set forth in Section 7-203 of the
18 Illinois Vehicle Code shall be subject to the following rules:

19 (A) If at least 60 days' written notice of the
20 intention to offer the following documents in evidence is
21 given to every other party, accompanied by a copy of the
22 document, a party may offer in evidence, without
23 foundation or other proof:

24 (1) bills, records, and reports of hospitals,
25 doctors, dentists, registered nurses, licensed
26 practical nurses, physical therapists, and other

1 healthcare providers;

2 (2) bills for drugs, medical appliances, and
3 prostheses;

4 (3) property repair bills or estimates, when
5 identified and itemized setting forth the charges for
6 labor and material used or proposed for use in the
7 repair of the property;

8 (4) a report of the rate of earnings and time lost
9 from work or lost compensation prepared by an
10 employer;

11 (5) the written opinion of an opinion witness, the
12 deposition of a witness, and the statement of a
13 witness that the witness would be allowed to express
14 if testifying in person, if the opinion or statement
15 is made by affidavit or by certification as provided
16 in Section 1-109 of the Code of Civil Procedure;

17 (6) any other document not specifically covered by
18 any of the foregoing provisions that is otherwise
19 admissible under the rules of evidence.

20 Any party receiving a notice under this paragraph (A)
21 may apply to the arbitrator or panel of arbitrators, as
22 the case may be, for the issuance of a subpoena directed to
23 the author or maker or custodian of the document that is
24 the subject of the notice, requiring the person subpoenaed
25 to produce copies of any additional documents as may be
26 related to the subject matter of the document that is the

1 subject of the notice. Any such subpoena shall be issued
2 in substantially similar form and served by notice as
3 provided by Illinois Supreme Court Rule 204(a)(4). Any
4 such subpoena shall be returnable not less than 5 days
5 before the arbitration hearing.

6 (B) Notwithstanding the provisions of Supreme Court
7 Rule 213(g), a party who proposes to use a written opinion
8 of an expert or opinion witness or the testimony of an
9 expert or opinion witness at the hearing may do so
10 provided a written notice of that intention is given to
11 every other party not less than 60 days prior to the date
12 of hearing, accompanied by a statement containing the
13 identity of the witness, his or her qualifications, the
14 subject matter, the basis of the witness's conclusions,
15 and his or her opinion.

16 (C) Any other party may subpoena the author or maker
17 of a document admissible under this subsection, at that
18 party's expense, and examine the author or maker as if
19 under cross-examination. The provisions of Section 2-1101
20 of the Code of Civil Procedure shall be applicable to
21 arbitration hearings, and it shall be the duty of a party
22 requesting the subpoena to modify the form to show that
23 the appearance is set before an arbitration panel and to
24 give the time and place set for the hearing.

25 (D) The provisions of Section 2-1102 of the Code of
26 Civil Procedure shall be applicable to arbitration

1 hearings under this subsection.

2 (2) No policy insuring against loss resulting from
3 liability imposed by law for property damage arising out of
4 the ownership, maintenance, or use of a motor vehicle shall be
5 renewed, delivered, or issued for delivery in this State with
6 respect to any private passenger or recreational motor vehicle
7 that is designed for use on public highways and that is either
8 required to be registered in this State or is principally
9 garaged in this State ~~and is not covered by collision~~
10 ~~insurance under the provisions of such policy~~, unless coverage
11 is made available in the amount of the actual cash value of the
12 motor vehicle described in the policy or the corresponding
13 policy limit for uninsured motor vehicle property damage
14 coverage, \$15,000 whichever is less, subject to a maximum \$250
15 deductible, for the protection of persons insured thereunder
16 who are legally entitled to recover damages from owners or
17 operators of uninsured motor vehicles and hit-and-run motor
18 vehicles because of property damage to the motor vehicle
19 described in the policy.

20 There shall be no liability imposed under the uninsured
21 motorist property damage coverage required by this subsection
22 if the owner or operator of the at-fault uninsured motor
23 vehicle or hit-and-run motor vehicle cannot be identified.
24 This subsection shall not apply to any policy which does not
25 provide primary motor vehicle liability insurance for
26 liabilities arising from the maintenance, operation, or use of

1 a specifically insured motor vehicle.

2 Each insurance company providing motor vehicle property
3 damage liability insurance shall advise applicants of the
4 availability of uninsured motor vehicle property damage
5 coverage, the premium therefor, and provide a brief
6 description of the coverage. That information need be given
7 only once and shall not be required in any subsequent renewal,
8 reinstatement or reissuance, substitute, amended, replacement
9 or supplementary policy. No written rejection shall be
10 required, and the absence of a premium payment for uninsured
11 motor vehicle property damage shall constitute conclusive
12 proof that the applicant or policyholder has elected not to
13 accept uninsured motorist property damage coverage.

14 An insurance company issuing uninsured motor vehicle
15 property damage coverage may provide that:

16 (i) Property damage losses recoverable thereunder
17 shall be limited to damages caused by the actual physical
18 contact of an uninsured motor vehicle with the insured
19 motor vehicle.

20 (ii) There shall be no coverage for loss of use of the
21 insured motor vehicle and no coverage for loss or damage
22 to personal property located in the insured motor vehicle.

23 (iii) Any claim submitted shall include the name and
24 address of the owner of the at-fault uninsured motor
25 vehicle, or a registration number and description of the
26 vehicle, or any other available information to establish

1 that there is no applicable motor vehicle property damage
2 liability insurance.

3 Any dispute with respect to the coverage and the amount of
4 damages shall be submitted for arbitration to the American
5 Arbitration Association and be subject to its rules for the
6 conduct of arbitration hearings or for determination in the
7 following manner: Upon the insured requesting arbitration,
8 each party to the dispute shall select an arbitrator and the 2
9 arbitrators so named shall select a third arbitrator. If such
10 arbitrators are not selected within 45 days from such request,
11 either party may request that the arbitration be submitted to
12 the American Arbitration Association. Any arbitration
13 proceeding under this subsection seeking recovery for property
14 damages shall be subject to the following rules:

15 (A) If at least 60 days' written notice of the
16 intention to offer the following documents in evidence is
17 given to every other party, accompanied by a copy of the
18 document, a party may offer in evidence, without
19 foundation or other proof:

20 (1) property repair bills or estimates, when
21 identified and itemized setting forth the charges for
22 labor and material used or proposed for use in the
23 repair of the property;

24 (2) the written opinion of an opinion witness, the
25 deposition of a witness, and the statement of a
26 witness that the witness would be allowed to express

1 if testifying in person, if the opinion or statement
2 is made by affidavit or by certification as provided
3 in Section 1-109 of the Code of Civil Procedure;

4 (3) any other document not specifically covered by
5 any of the foregoing provisions that is otherwise
6 admissible under the rules of evidence.

7 Any party receiving a notice under this paragraph (A)
8 may apply to the arbitrator or panel of arbitrators, as
9 the case may be, for the issuance of a subpoena directed to
10 the author or maker or custodian of the document that is
11 the subject of the notice, requiring the person subpoenaed
12 to produce copies of any additional documents as may be
13 related to the subject matter of the document that is the
14 subject of the notice. Any such subpoena shall be issued
15 in substantially similar form and served by notice as
16 provided by Illinois Supreme Court Rule 204(a)(4). Any
17 such subpoena shall be returnable not less than 5 days
18 before the arbitration hearing.

19 (B) Notwithstanding the provisions of Supreme Court
20 Rule 213(g), a party who proposes to use a written opinion
21 of an expert or opinion witness or the testimony of an
22 expert or opinion witness at the hearing may do so
23 provided a written notice of that intention is given to
24 every other party not less than 60 days prior to the date
25 of hearing, accompanied by a statement containing the
26 identity of the witness, his or her qualifications, the

1 subject matter, the basis of the witness's conclusions,
2 and his or her opinion.

3 (C) Any other party may subpoena the author or maker
4 of a document admissible under this subsection, at that
5 party's expense, and examine the author or maker as if
6 under cross-examination. The provisions of Section 2-1101
7 of the Code of Civil Procedure shall be applicable to
8 arbitration hearings, and it shall be the duty of a party
9 requesting the subpoena to modify the form to show that
10 the appearance is set before an arbitration panel and to
11 give the time and place set for the hearing.

12 (D) The provisions of Section 2-1102 of the Code of
13 Civil Procedure shall be applicable to arbitration
14 hearings under this subsection.

15 (3) For the purpose of the coverage, the term "uninsured
16 motor vehicle" includes, subject to the terms and conditions
17 of the coverage, a motor vehicle where on, before or after the
18 accident date the liability insurer thereof is unable to make
19 payment with respect to the legal liability of its insured
20 within the limits specified in the policy because of the entry
21 by a court of competent jurisdiction of an order of
22 rehabilitation or liquidation by reason of insolvency on or
23 after the accident date. An insurer's extension of coverage,
24 as provided in this subsection, shall be applicable to all
25 accidents occurring after July 1, 1967 during a policy period
26 in which its insured's uninsured motor vehicle coverage is in

1 effect. Nothing in this Section may be construed to prevent
2 any insurer from extending coverage under terms and conditions
3 more favorable to its insureds than is required by this
4 Section.

5 (4) In the event of payment to any person under the
6 coverage required by this Section and subject to the terms and
7 conditions of the coverage, the insurer making the payment
8 shall, to the extent thereof, be entitled to the proceeds of
9 any settlement or judgment resulting from the exercise of any
10 rights of recovery of the person against any person or
11 organization legally responsible for the property damage,
12 bodily injury or death for which the payment is made,
13 including the proceeds recoverable from the assets of the
14 insolvent insurer. With respect to payments made by reason of
15 the coverage described in subsection (3), the insurer making
16 such payment shall not be entitled to any right of recovery
17 against the tortfeasor in excess of the proceeds recovered
18 from the assets of the insolvent insurer of the tortfeasor.

19 (5) This amendatory Act of 1967 (Laws of Illinois 1967,
20 page 875) shall not be construed to terminate or reduce any
21 insurance coverage or any right of any party under this Code in
22 effect before July 1, 1967. Public Act 86-1155 shall not be
23 construed to terminate or reduce any insurance coverage or any
24 right of any party under this Code in effect before its
25 effective date.

26 (6) Failure of the motorist from whom the claimant is

1 legally entitled to recover damages to file the appropriate
2 forms with the Safety Responsibility Section of the Department
3 of Transportation within 120 days of the accident date shall
4 create a rebuttable presumption that the motorist was
5 uninsured at the time of the injurious occurrence.

6 (7) An insurance carrier may upon good cause require the
7 insured to commence a legal action against the owner or
8 operator of an uninsured motor vehicle before good faith
9 negotiation with the carrier. If the action is commenced at
10 the request of the insurance carrier, the carrier shall pay to
11 the insured, before the action is commenced, all court costs,
12 jury fees and sheriff's fees arising from the action.

13 The changes made by Public Act 90-451 apply to all
14 policies of insurance amended, delivered, issued, or renewed
15 on and after January 1, 1998 (the effective date of Public Act
16 90-451).

17 (8) The changes made by Public Act 98-927 apply to all
18 policies of insurance amended, delivered, issued, or renewed
19 on and after January 1, 2015 (the effective date of Public Act
20 98-927).

21 (Source: P.A. 98-242, eff. 1-1-14; 98-927, eff. 1-1-15;
22 99-642, eff. 7-28-16.)

23 (215 ILCS 5/229.4a)

24 Sec. 229.4a. Standard Non-forfeiture Law for Individual
25 Deferred Annuities.

1 (1) Title. This Section shall be known as the Standard
2 Nonforfeiture Law for Individual Deferred Annuities.

3 (2) Applicability. This Section shall not apply to any
4 reinsurance, group annuity purchased under a retirement plan
5 or plan of deferred compensation established or maintained by
6 an employer (including a partnership or sole proprietorship)
7 or by an employee organization, or by both, other than a plan
8 providing individual retirement accounts or individual
9 retirement annuities under Section 408 of the Internal Revenue
10 Code, as now or hereafter amended, premium deposit fund,
11 variable annuity, investment annuity, immediate annuity, any
12 deferred annuity contract after annuity payments have
13 commenced, or reversionary annuity, nor to any contract which
14 shall be delivered outside this State through an agent or
15 other representative of the company issuing the contract.

16 (3) Nonforfeiture Requirements.

17 (A) In the case of contracts issued on or after the
18 operative date of this Section as defined in subsection
19 (13), no contract of annuity, except as stated in
20 subsection (2), shall be delivered or issued for delivery
21 in this State unless it contains in substance the
22 following provisions, or corresponding provisions which in
23 the opinion of the Director of Insurance are at least as
24 favorable to the contract holder, upon cessation of
25 payment of considerations under the contract:

26 (i) That upon cessation of payment of

1 considerations under a contract, or upon the written
2 request of the contract owner, the company shall grant
3 a paid-up annuity benefit on a plan stipulated in the
4 contract of such value as is specified in subsections
5 (5), (6), (7), (8) and (10);

6 (ii) If a contract provides for a lump sum
7 settlement at maturity, or at any other time, that
8 upon surrender of the contract at or prior to the
9 commencement of any annuity payments, the company
10 shall pay in lieu of a paid-up annuity benefit a cash
11 surrender benefit of such amount as is specified in
12 subsections (5), (6), (8) and (10). The company may
13 reserve the right to defer the payment of the cash
14 surrender benefit for a period not to exceed 6 months
15 after demand therefor with surrender of the contract
16 after making written request and receiving written
17 approval of the Director. The request shall address
18 the necessity and equitability to all policyholders of
19 the deferral;

20 (iii) A statement of the mortality table, if any,
21 and interest rates used calculating any minimum
22 paid-up annuity, cash surrender, or death benefits
23 that are guaranteed under the contract, together with
24 sufficient information to determine the amounts of the
25 benefits; and

26 (iv) A statement that any paid-up annuity, cash

1 surrender or death benefits that may be available
2 under the contract are not less than the minimum
3 benefits required by any statute of the state in which
4 the contract is delivered and an explanation of the
5 manner in which the benefits are altered by the
6 existence of any additional amounts credited by the
7 company to the contract, any indebtedness to the
8 company on the contract or any prior withdrawals from
9 or partial surrenders of the contract.

10 (B) Notwithstanding the requirements of this Section,
11 a deferred annuity contract may provide that if no
12 considerations have been received under a contract for a
13 period of 2 full years and the portion of the paid-up
14 annuity benefit at maturity on the plan stipulated in the
15 contract arising from prior considerations paid would be
16 less than \$20 monthly, the company may at its option
17 terminate the contract by payment in cash of the then
18 present value of the portion of the paid-up annuity
19 benefit, calculated on the basis on the mortality table,
20 if any, and interest rate specified in the contract for
21 determining the paid-up annuity benefit, and by this
22 payment shall be relieved of any further obligation under
23 the contract.

24 (4) Minimum values. The minimum values as specified in
25 subsections (5), (6), (7), (8) and (10) of any paid-up
26 annuity, cash surrender or death benefits available under an

1 annuity contract shall be based upon minimum nonforfeiture
2 amounts as defined in this subsection.

3 (A) (i) The minimum nonforfeiture amount at any time at
4 or prior to the commencement of any annuity payments shall
5 be equal to an accumulation up to such time at rates of
6 interest as indicated in subdivision (4) (B) of the net
7 considerations (as hereinafter defined) paid prior to such
8 time, decreased by the sum of paragraphs (a) through (d)
9 below:

10 (a) Any prior withdrawals from or partial
11 surrenders of the contract accumulated at rates of
12 interest as indicated in subdivision (4) (B);

13 (b) An annual contract charge of \$50, accumulated
14 at rates of interest as indicated in subdivision
15 (4) (B);

16 (c) Any premium tax paid by the company for the
17 contract, accumulated at rates of interest as
18 indicated in subdivision (4) (B); and

19 (d) The amount of any indebtedness to the company
20 on the contract, including interest due and accrued.

21 (ii) The net considerations for a given contract year
22 used to define the minimum nonforfeiture amount shall be
23 an amount equal to 87.5% of the gross considerations,
24 credited to the contract during that contract year.

25 (B) The interest rate used in determining minimum
26 nonforfeiture amounts shall be an annual rate of interest

1 determined as the lesser of 3% per annum and the
2 following, which shall be specified in the contract if the
3 interest rate will be reset:

4 (i) The five-year Constant Maturity Treasury Rate
5 reported by the Federal Reserve as of a date, or
6 average over a period, rounded to the nearest 1/20th
7 of one percent, specified in the contract no longer
8 than 15 months prior to the contract issue date or
9 redetermination date under subdivision (4) (B) (iv);

10 (ii) Reduced by 125 basis points;

11 (iii) Where the resulting interest rate is not
12 less than 0.15% ~~1%~~; and

13 (iv) The interest rate shall apply for an initial
14 period and may be redetermined for additional periods.
15 The redetermination date, basis and period, if any,
16 shall be stated in the contract. The basis is the date
17 or average over a specified period that produces the
18 value of the 5-year Constant Maturity Treasury Rate to
19 be used at each redetermination date.

20 (C) During the period or term that a contract provides
21 substantive participation in an equity indexed benefit, it
22 may increase the reduction described in subdivision
23 (4) (B) (ii) above by up to an additional 100 basis points
24 to reflect the value of the equity index benefit. The
25 present value at the contract issue date, and at each
26 redetermination date thereafter, of the additional

1 reduction shall not exceed market value of the benefit.
2 The Director may require a demonstration that the present
3 value of the additional reduction does not exceed the
4 market value of the benefit. Lacking such a demonstration
5 that is acceptable to the Director, the Director may
6 disallow or limit the additional reduction.

7 (D) The Director may adopt rules to implement the
8 provisions of subdivision (4)(C) and to provide for
9 further adjustments to the calculation of minimum
10 nonforfeiture amounts for contracts that provide
11 substantive participation in an equity index benefit and
12 for other contracts that the Director determines
13 adjustments are justified.

14 (5) Computation of Present Value. Any paid-up annuity
15 benefit available under a contract shall be such that its
16 present value on the date annuity payments are to commence is
17 at least equal to the minimum nonforfeiture amount on that
18 date. Present value shall be computed using the mortality
19 table, if any, and the interest rates specified in the
20 contract for determining the minimum paid-up annuity benefits
21 guaranteed in the contract.

22 (6) Calculation of Cash Surrender Value. For contracts
23 that provide cash surrender benefits, the cash surrender
24 benefits available prior to maturity shall not be less than
25 the present value as of the date of surrender of that portion
26 of the maturity value of the paid-up annuity benefit that

1 would be provided under the contract at maturity arising from
2 considerations paid prior to the time of cash surrender
3 reduced by the amount appropriate to reflect any prior
4 withdrawals from or partial surrenders of the contract, such
5 present value being calculated on the basis of an interest
6 rate not more than 1% higher than the interest rate specified
7 in the contract for accumulating the net considerations to
8 determine maturity value, decreased by the amount of any
9 indebtedness to the company on the contract, including
10 interest due and accrued, and increased by any existing
11 additional amounts credited by the company to the contract. In
12 no event shall any cash surrender benefit be less than the
13 minimum nonforfeiture amount at that time. The death benefit
14 under such contracts shall be at least equal to the cash
15 surrender benefit.

16 (7) Calculation of Paid-up Annuity Benefits. For contracts
17 that do not provide cash surrender benefits, the present value
18 of any paid-up annuity benefit available as a nonforfeiture
19 option at any time prior to maturity shall not be less than the
20 present value of that portion of the maturity value of the
21 paid-up annuity benefit provided under the contract arising
22 from considerations paid prior to the time the contract is
23 surrendered in exchange for, or changed to, a deferred paid-up
24 annuity, such present value being calculated for the period
25 prior to the maturity date on the basis of the interest rate
26 specified in the contract for accumulating the net

1 considerations to determine maturity value, and increased by
2 any additional amounts credited by the company to the
3 contract. For contracts that do not provide any death benefits
4 prior to the commencement of any annuity payments, present
5 values shall be calculated on the basis of such interest rate
6 and the mortality table specified in the contract for
7 determining the maturity value of the paid-up annuity benefit.
8 However, in no event shall the present value of a paid-up
9 annuity benefit be less than the minimum nonforfeiture amount
10 at that time.

11 (8) Maturity Date. For the purpose of determining the
12 benefits calculated under subsections (6) and (7), in the case
13 of annuity contracts under which an election may be made to
14 have annuity payments commence at optional maturity dates, the
15 maturity date shall be deemed to be the latest date for which
16 election shall be permitted by the contract, but shall not be
17 deemed to be later than the anniversary of the contract next
18 following the annuitant's seventieth birthday or the tenth
19 anniversary of the contract, whichever is later.

20 (9) Disclosure of Limited Death Benefits. A contract that
21 does not provide cash surrender benefits or does not provide
22 death benefits at least equal to the minimum nonforfeiture
23 amount prior to the commencement of any annuity payments shall
24 include a statement in a prominent place in the contract that
25 such benefits are not provided.

26 (10) Inclusion of Lapse of Time Considerations. Any

1 paid-up annuity, cash surrender or death benefits available at
2 any time, other than on the contract anniversary under any
3 contract with fixed scheduled considerations, shall be
4 calculated with allowance for the lapse of time and the
5 payment of any scheduled considerations beyond the beginning
6 of the contract year in which cessation of payment of
7 considerations under the contract occurs.

8 (11) Proration of Values; Additional Benefits. For a
9 contract which provides, within the same contract by rider or
10 supplemental contract provision, both annuity benefits and
11 life insurance benefits that are in excess of the greater of
12 cash surrender benefits or a return of the gross
13 considerations with interest, the minimum nonforfeiture
14 benefits shall be equal to the sum of the minimum
15 nonforfeiture benefits for the annuity portion and the minimum
16 nonforfeiture benefits, if any, for the life insurance portion
17 computed as if each portion were a separate contract.
18 Notwithstanding the provisions of subsections (5), (6), (7),
19 (8) and (10), additional benefits payable in the event of
20 total and permanent disability, as reversionary annuity or
21 deferred reversionary annuity benefits, or as other policy
22 benefits additional to life insurance, endowment and annuity
23 benefits, and considerations for all such additional benefits,
24 shall be disregarded in ascertaining the minimum nonforfeiture
25 amounts, paid-up annuity, cash surrender and death benefits
26 that may be required under this Section. The inclusion of such

1 benefits shall not be required in any paid-up benefits, unless
2 the additional benefits separately would require minimum
3 nonforfeiture amounts, paid-up annuity, cash surrender and
4 death benefits.

5 (12) Rules. The Director may adopt rules to implement the
6 provisions of this Section.

7 (13) Effective Date. After the effective date of this
8 amendatory Act of the 93rd General Assembly, a company may
9 elect to apply its provisions to annuity contracts on a
10 contract form-by-contract form basis before July 1, 2006. In
11 all other instances, this Section shall become operative with
12 respect to annuity contracts issued by the company on or after
13 July 1, 2006.

14 (14) (Blank).

15 (Source: P.A. 93-873, eff. 8-6-04; 94-1076, eff. 12-29-06.)

16 (215 ILCS 5/353a) (from Ch. 73, par. 965a)

17 Sec. 353a. Accident and health reserves.

18 The reserves for all accident and health policies issued
19 after the operative date of this section shall be computed and
20 maintained on a basis which shall place an actuarially sound
21 value on the liabilities under such policies. To provide a
22 basis for the determination of such actuarially sound value,
23 the Director from time to time shall adopt rules requiring the
24 use of appropriate tables of morbidity, mortality, interest
25 rates and valuation methods for such reserves for policies

1 issued before January 1, 2017. For policies issued on or after
2 January 1, 2017, Section 223 shall govern the basis for
3 determining such actuarially sound value. In no event shall
4 such reserves be less than the pro rata gross unearned premium
5 reserve for such policies.

6 The company shall give the notice required in section 234
7 on all non-cancellable accident and health policies.

8 After this section becomes effective, any company may file
9 with the Director written notice of its election to comply
10 with the provisions of this section after a specified date
11 before January 1, 1967. After the filing of such notice, then
12 upon such specified date (which shall be the operative date of
13 this section for such company), this section shall become
14 operative with respect to the accident and health policies
15 thereafter issued by such company. If a company makes no such
16 election, the operative date of this section for such company
17 shall be January 1, 1967.

18 After this section becomes effective, any company may file
19 with the Director written notice of its election to establish
20 and maintain reserves upon its accident and health policies
21 issued prior to the operative date of this section in
22 accordance with the standards for reserves established by this
23 section, and thereafter the reserve standards prescribed
24 pursuant to this section shall be effective with respect to
25 said accident and health policies issued prior to the
26 operative date of this section.

1 (Source: Laws 1965, p. 740.)

2 (215 ILCS 5/355a) (from Ch. 73, par. 967a)

3 Sec. 355a. Standardization of terms and coverage.

4 (1) The purposes of this Section shall be (a) to provide
5 reasonable standardization and simplification of terms and
6 coverages of individual accident and health insurance policies
7 to facilitate public understanding and comparisons; (b) to
8 eliminate provisions contained in individual accident and
9 health insurance policies which may be misleading or
10 unreasonably confusing in connection either with the purchase
11 of such coverages or with the settlement of claims; and (c) to
12 provide for reasonable disclosure in the sale of accident and
13 health coverages.

14 (2) Definitions applicable to this Section are as follows:

15 (a) "Policy" means all or any part of the forms
16 constituting the contract between the insurer and the
17 insured, including the policy, certificate, subscriber
18 contract, riders, endorsements, and the application if
19 attached, which are subject to filing with and approval by
20 the Director.

21 (b) "Service corporations" means voluntary health and
22 dental corporations organized and operating respectively
23 under the Voluntary Health Services Plans Act and the
24 Dental Service Plan Act.

25 (c) "Accident and health insurance" means insurance

1 written under Article XX of this Code, other than credit
2 accident and health insurance, and coverages provided in
3 subscriber contracts issued by service corporations. For
4 purposes of this Section such service corporations shall
5 be deemed to be insurers engaged in the business of
6 insurance.

7 (3) The Director shall issue such rules as he shall deem
8 necessary or desirable to establish specific standards,
9 including standards of full and fair disclosure that set forth
10 the form and content and required disclosure for sale, of
11 individual policies of accident and health insurance, which
12 rules and regulations shall be in addition to and in
13 accordance with the applicable laws of this State, and which
14 may cover but shall not be limited to: (a) terms of
15 renewability; (b) initial and subsequent conditions of
16 eligibility; (c) non-duplication of coverage provisions; (d)
17 coverage of dependents; (e) pre-existing conditions; (f)
18 termination of insurance; (g) probationary periods; (h)
19 limitation, exceptions, and reductions; (i) elimination
20 periods; (j) requirements regarding replacements; (k)
21 recurrent conditions; and (l) the definition of terms,
22 including, but not limited to, the following: hospital,
23 accident, sickness, injury, physician, accidental means, total
24 disability, partial disability, nervous disorder, guaranteed
25 renewable, and non-cancellable.

26 The Director may issue rules that specify prohibited

1 policy provisions not otherwise specifically authorized by
2 statute which in the opinion of the Director are unjust,
3 unfair or unfairly discriminatory to the policyholder, any
4 person insured under the policy, or beneficiary.

5 (4) The Director shall issue such rules as he shall deem
6 necessary or desirable to establish minimum standards for
7 benefits under each category of coverage in individual
8 accident and health policies, other than conversion policies
9 issued pursuant to a contractual conversion privilege under a
10 group policy, including but not limited to the following
11 categories: (a) basic hospital expense coverage; (b) basic
12 medical-surgical expense coverage; (c) hospital confinement
13 indemnity coverage; (d) major medical expense coverage; (e)
14 disability income protection coverage; (f) accident only
15 coverage; and (g) specified disease or specified accident
16 coverage.

17 Nothing in this subsection (4) shall preclude the issuance
18 of any policy which combines two or more of the categories of
19 coverage enumerated in subparagraphs (a) through (f) of this
20 subsection.

21 No policy shall be delivered or issued for delivery in
22 this State which does not meet the prescribed minimum
23 standards for the categories of coverage listed in this
24 subsection unless the Director finds that such policy is
25 necessary to meet specific needs of individuals or groups and
26 such individuals or groups will be adequately informed that

1 such policy does not meet the prescribed minimum standards,
2 and such policy meets the requirement that the benefits
3 provided therein are reasonable in relation to the premium
4 charged. The standards and criteria to be used by the Director
5 in approving such policies shall be included in the rules
6 required under this Section with as much specificity as
7 practicable.

8 The Director shall prescribe by rule the method of
9 identification of policies based upon coverages provided.

10 (5) (a) In order to provide for full and fair disclosure in
11 the sale of individual accident and health insurance policies,
12 no such policy shall be delivered or issued for delivery in
13 this State unless the outline of coverage described in
14 paragraph (b) of this subsection either accompanies the
15 policy, or is delivered to the applicant at the time the
16 application is made, and an acknowledgment signed by the
17 insured, of receipt of delivery of such outline, is provided
18 to the insurer. In the event the policy is issued on a basis
19 other than that applied for, the outline of coverage properly
20 describing the policy must accompany the policy when it is
21 delivered and such outline shall clearly state that the policy
22 differs, and to what extent, from that for which application
23 was originally made. All policies, except single premium
24 nonrenewal policies, shall have a notice prominently printed
25 on the first page of the policy or attached thereto stating in
26 substance, that the policyholder shall have the right to

1 return the policy within 10 days of its delivery and to have
2 the premium refunded if after examination of the policy the
3 policyholder is not satisfied for any reason.

4 (b) The Director shall issue such rules as he shall deem
5 necessary or desirable to prescribe the format and content of
6 the outline of coverage required by paragraph (a) of this
7 subsection. "Format" means style, arrangement, and overall
8 appearance, including such items as the size, color, and
9 prominence of type and the arrangement of text and captions.
10 "Content" shall include without limitation thereto, statements
11 relating to the particular policy as to the applicable
12 category of coverage prescribed under subsection (4);
13 principal benefits; exceptions, reductions and limitations;
14 and renewal provisions, including any reservation by the
15 insurer of a right to change premiums. Such outline of
16 coverage shall clearly state that it constitutes a summary of
17 the policy issued or applied for and that the policy should be
18 consulted to determine governing contractual provisions.

19 (c) (Blank). ~~Without limiting the generality of paragraph~~
20 ~~(b) of this subsection (5), no qualified health plans shall be~~
21 ~~offered for sale directly to consumers through the health~~
22 ~~insurance marketplace operating in the State in accordance~~
23 ~~with Sections 1311 and 1321 of the federal Patient Protection~~
24 ~~and Affordable Care Act of 2010 (Public Law 111 148), as~~
25 ~~amended by the federal Health Care and Education~~
26 ~~Reconciliation Act of 2010 (Public Law 111 152), and any~~

1 ~~amendments thereto, or regulations or guidance issued~~
2 ~~thereunder (collectively, "the Federal Act"), unless the~~
3 ~~following information is made available to the consumer at the~~
4 ~~time he or she is comparing policies and their premiums:~~

5 ~~(i) With respect to prescription drug benefits, the~~
6 ~~most recently published formulary where a consumer can~~
7 ~~view in one location covered prescription drugs;~~
8 ~~information on tiering and the cost sharing structure for~~
9 ~~each tier; and information about how a consumer can obtain~~
10 ~~specific copayment amounts or coinsurance percentages for~~
11 ~~a specific qualified health plan before enrolling in that~~
12 ~~plan. This information shall clearly identify the~~
13 ~~qualified health plan to which it applies.~~

14 ~~(ii) The most recently published provider directory~~
15 ~~where a consumer can view the provider network that~~
16 ~~applies to each qualified health plan and information~~
17 ~~about each provider, including location, contact~~
18 ~~information, specialty, medical group, if any, any~~
19 ~~institutional affiliation, and whether the provider is~~
20 ~~accepting new patients at each of the specific locations~~
21 ~~listing the provider. Dental providers shall notify~~
22 ~~qualified health plans electronically or in writing of any~~
23 ~~changes to their information as listed in the provider~~
24 ~~directory. Qualified health plans shall update their~~
25 ~~directories in a manner consistent with the information~~
26 ~~provided by the provider or dental management service~~

1 ~~organization within 10 business days after being notified~~
2 ~~of the change by the provider. Nothing in this paragraph~~
3 ~~(ii) shall void any contractual relationship between the~~
4 ~~provider and the plan. The information shall clearly~~
5 ~~identify the qualified health plan to which it applies.~~

6 (d) (Blank). ~~Each company that offers qualified health~~
7 ~~plans for sale directly to consumers through the health~~
8 ~~insurance marketplace operating in the State shall make the~~
9 ~~information in paragraph (c) of this subsection (5), for each~~
10 ~~qualified health plan that it offers, available and accessible~~
11 ~~to the general public on the company's Internet website and~~
12 ~~through other means for individuals without access to the~~
13 ~~Internet.~~

14 (e) (Blank). ~~The Department shall ensure that~~
15 ~~State operated Internet websites, in addition to the Internet~~
16 ~~website for the health insurance marketplace established in~~
17 ~~this State in accordance with the Federal Act, prominently~~
18 ~~provide links to Internet based materials and tools to help~~
19 ~~consumers be informed purchasers of health insurance.~~

20 (f) (Blank). ~~Nothing in this Section shall be interpreted~~
21 ~~or implemented in a manner not consistent with the Federal~~
22 ~~Act. This Section shall apply to all qualified health plans~~
23 ~~offered for sale directly to consumers through the health~~
24 ~~insurance marketplace operating in this State for any coverage~~
25 ~~year beginning on or after January 1, 2015.~~

26 (g) Prior to the issuance of rules pursuant to this

1 Section, the Director shall afford the public, including the
2 companies affected thereby, reasonable opportunity for
3 comment. Such rulemaking is subject to the provisions of the
4 Illinois Administrative Procedure Act.

5 (7) When a rule has been adopted, pursuant to this
6 Section, all policies of insurance or subscriber contracts
7 which are not in compliance with such rule shall, when so
8 provided in such rule, be deemed to be disapproved as of a date
9 specified in such rule not less than 120 days following its
10 effective date, without any further or additional notice other
11 than the adoption of the rule.

12 (8) When a rule adopted pursuant to this Section so
13 provides, a policy of insurance or subscriber contract which
14 does not comply with the rule shall, not less than 120 days
15 from the effective date of such rule, be construed, and the
16 insurer or service corporation shall be liable, as if the
17 policy or contract did comply with the rule.

18 (9) Violation of any rule adopted pursuant to this Section
19 shall be a violation of the insurance law for purposes of
20 Sections 370 and 446 of this Code.

21 (Source: P.A. 99-329, eff. 1-1-16; 100-201, eff. 8-18-17.)

22 (215 ILCS 5/355c new)

23 Sec. 355c. Availability of information on qualified health
24 plans.

25 (a) Without limiting the generality of paragraph (b) of

1 subsection (5) of Section 355a, no qualified health plans
2 shall be offered for sale directly to consumers through the
3 health insurance marketplace operating in this State in
4 accordance with Sections 1311 and 1321 of the federal Patient
5 Protection and Affordable Care Act of 2010 (Public Law
6 111-148), as amended by the federal Health Care and Education
7 Reconciliation Act of 2010 (Public Law 111-152), and any
8 amendments thereto, or regulations or guidance issued
9 thereunder (collectively, "the Federal Act"), unless the
10 following information is made available to the consumer at the
11 time he or she is comparing policies and their premiums:

12 (1) With respect to prescription drug benefits, the
13 most recently published formulary where a consumer can
14 view in one location covered prescription drugs;
15 information on tiering and the cost-sharing structure for
16 each tier; and information about how a consumer can obtain
17 specific copayment amounts or coinsurance percentages for
18 a specific qualified health plan before enrolling in that
19 plan. This information shall clearly identify the
20 qualified health plan to which it applies.

21 (2) The most recently published provider directory
22 where a consumer can view the provider network that
23 applies to each qualified health plan and information
24 about each provider, including location, contact
25 information, specialty, medical group, if any, any
26 institutional affiliation, and whether the provider is

1 accepting new patients at each of the specific locations
2 listing the provider. Dental providers shall notify
3 qualified health plans electronically or in writing of any
4 changes to their information as listed in the provider
5 directory. Qualified health plans shall update their
6 directories in a manner consistent with the information
7 provided by the provider or dental management service
8 organization within 10 business days after being notified
9 of the change by the provider. Nothing in this paragraph
10 (2) shall void any contractual relationship between the
11 provider and the plan. The information shall clearly
12 identify the qualified health plan to which it applies.

13 (b) Each company that offers qualified health plans for
14 sale directly to consumers through the health insurance
15 marketplace operating in this State shall make the information
16 in subsection (a), for each qualified health plan that it
17 offers, available and accessible to the general public on the
18 company's website and through other means for individuals
19 without access to the Internet.

20 (c) The Department shall ensure that State-operated
21 websites, in addition to the website for the health insurance
22 marketplace established in this State in accordance with the
23 Federal Act, prominently provide links to Internet-based
24 materials and tools to help consumers be informed purchasers
25 of health insurance.

26 (d) Nothing in this Section shall be interpreted or

1 implemented in a manner not consistent with the Federal Act.
2 This Section shall apply to all qualified health plans offered
3 for sale directly to consumers through the health insurance
4 marketplace operating in this State for any coverage year
5 beginning on or after January 1, 2015.

6 (215 ILCS 5/408) (from Ch. 73, par. 1020)

7 Sec. 408. Fees and charges.

8 (1) The Director shall charge, collect and give proper
9 acquittances for the payment of the following fees and
10 charges:

11 (a) For filing all documents submitted for the
12 incorporation or organization or certification of a
13 domestic company, except for a fraternal benefit society,
14 \$2,000.

15 (b) For filing all documents submitted for the
16 incorporation or organization of a fraternal benefit
17 society, \$500.

18 (c) For filing amendments to articles of incorporation
19 and amendments to declaration of organization, except for
20 a fraternal benefit society, a mutual benefit association,
21 a burial society or a farm mutual, \$200.

22 (d) For filing amendments to articles of incorporation
23 of a fraternal benefit society, a mutual benefit
24 association or a burial society, \$100.

25 (e) For filing amendments to articles of incorporation

1 of a farm mutual, \$50.

2 (f) For filing bylaws or amendments thereto, \$50.

3 (g) For filing agreement of merger or consolidation:

4 (i) for a domestic company, except for a fraternal
5 benefit society, a mutual benefit association, a
6 burial society, or a farm mutual, \$2,000.

7 (ii) for a foreign or alien company, except for a
8 fraternal benefit society, \$600.

9 (iii) for a fraternal benefit society, a mutual
10 benefit association, a burial society, or a farm
11 mutual, \$200.

12 (h) For filing agreements of reinsurance by a domestic
13 company, \$200.

14 (i) For filing all documents submitted by a foreign or
15 alien company to be admitted to transact business or
16 accredited as a reinsurer in this State, except for a
17 fraternal benefit society, \$5,000.

18 (j) For filing all documents submitted by a foreign or
19 alien fraternal benefit society to be admitted to transact
20 business in this State, \$500.

21 (k) For filing declaration of withdrawal of a foreign
22 or alien company, \$50.

23 (l) For filing annual statement by a domestic company,
24 except a fraternal benefit society, a mutual benefit
25 association, a burial society, or a farm mutual, \$200.

26 (m) For filing annual statement by a domestic

1 fraternal benefit society, \$100.

2 (n) For filing annual statement by a farm mutual, a
3 mutual benefit association, or a burial society, \$50.

4 (o) For issuing a certificate of authority or renewal
5 thereof except to a foreign fraternal benefit society,
6 \$400.

7 (p) For issuing a certificate of authority or renewal
8 thereof to a foreign fraternal benefit society, \$200.

9 (q) For issuing an amended certificate of authority,
10 \$50.

11 (r) For each certified copy of certificate of
12 authority, \$20.

13 (s) For each certificate of deposit, or valuation, or
14 compliance or surety certificate, \$20.

15 (t) For copies of papers or records per page, \$1.

16 (u) For each certification to copies of papers or
17 records, \$10.

18 (v) For multiple copies of documents or certificates
19 listed in subparagraphs (r), (s), and (u) of paragraph (1)
20 of this Section, \$10 for the first copy of a certificate of
21 any type and \$5 for each additional copy of the same
22 certificate requested at the same time, unless, pursuant
23 to paragraph (2) of this Section, the Director finds these
24 additional fees excessive.

25 (w) For issuing a permit to sell shares or increase
26 paid-up capital:

1 (i) in connection with a public stock offering,
2 \$300;

3 (ii) in any other case, \$100.

4 (x) For issuing any other certificate required or
5 permissible under the law, \$50.

6 (y) For filing a plan of exchange of the stock of a
7 domestic stock insurance company, a plan of
8 demutualization of a domestic mutual company, or a plan of
9 reorganization under Article XII, \$2,000.

10 (z) For filing a statement of acquisition of a
11 domestic company as defined in Section 131.4 of this Code,
12 \$2,000.

13 (aa) For filing an agreement to purchase the business
14 of an organization authorized under the Dental Service
15 Plan Act or the Voluntary Health Services Plans Act or of a
16 health maintenance organization or a limited health
17 service organization, \$2,000.

18 (bb) For filing a statement of acquisition of a
19 foreign or alien insurance company as defined in Section
20 131.12a of this Code, \$1,000.

21 (cc) For filing a registration statement as required
22 in Sections 131.13 and 131.14, the notification as
23 required by Sections 131.16, 131.20a, or 141.4, or an
24 agreement or transaction required by Sections 124.2(2),
25 141, 141a, or 141.1, \$200.

26 (dd) For filing an application for licensing of:

1 (i) a religious or charitable risk pooling trust
2 or a workers' compensation pool, \$1,000;

3 (ii) a workers' compensation service company,
4 \$500;

5 (iii) a self-insured automobile fleet, \$200; or

6 (iv) a renewal of or amendment of any license
7 issued pursuant to (i), (ii), or (iii) above, \$100.

8 (ee) For filing articles of incorporation for a
9 syndicate to engage in the business of insurance through
10 the Illinois Insurance Exchange, \$2,000.

11 (ff) For filing amended articles of incorporation for
12 a syndicate engaged in the business of insurance through
13 the Illinois Insurance Exchange, \$100.

14 (gg) For filing articles of incorporation for a
15 limited syndicate to join with other subscribers or
16 limited syndicates to do business through the Illinois
17 Insurance Exchange, \$1,000.

18 (hh) For filing amended articles of incorporation for
19 a limited syndicate to do business through the Illinois
20 Insurance Exchange, \$100.

21 (ii) For a permit to solicit subscriptions to a
22 syndicate or limited syndicate, \$100.

23 (jj) For the filing of each form as required in
24 Section 143 of this Code, \$50 per form. Informational and
25 advertising filings shall be \$25 per filing. The fee for
26 advisory and rating organizations shall be \$200 per form.

1 (i) For the purposes of the form filing fee,
2 filings made on insert page basis will be considered
3 one form at the time of its original submission.
4 Changes made to a form subsequent to its approval
5 shall be considered a new filing.

6 (ii) Only one fee shall be charged for a form,
7 regardless of the number of other forms or policies
8 with which it will be used.

9 (iii) Fees charged for a policy filed as it will be
10 issued regardless of the number of forms comprising
11 that policy shall not exceed \$1,500. For advisory or
12 rating organizations, fees charged for a policy filed
13 as it will be issued regardless of the number of forms
14 comprising that policy shall not exceed \$2,500.

15 (iv) The Director may by rule exempt forms from
16 such fees.

17 (kk) For filing an application for licensing of a
18 reinsurance intermediary, \$500.

19 (ll) For filing an application for renewal of a
20 license of a reinsurance intermediary, \$200.

21 (mm) For filing a plan of division of a domestic stock
22 company under Article IIB, \$10,000.

23 (nn) For filing all documents submitted by a foreign
24 or alien company to be a certified reinsurer in this
25 State, except for a fraternal benefit society, \$1,000.

26 (oo) For filing a renewal by a foreign or alien

1 company to be a certified reinsurer in this State, except
2 for a fraternal benefit society, \$400.

3 (pp) For filing all documents submitted by a reinsurer
4 domiciled in a reciprocal jurisdiction, \$1,000.

5 (qq) For filing a renewal by a reinsurer domiciled in
6 a reciprocal jurisdiction, \$400.

7 (rr) For registering a captive management company or
8 renewal thereof, \$50.

9 (2) When printed copies or numerous copies of the same
10 paper or records are furnished or certified, the Director may
11 reduce such fees for copies if he finds them excessive. He may,
12 when he considers it in the public interest, furnish without
13 charge to state insurance departments and persons other than
14 companies, copies or certified copies of reports of
15 examinations and of other papers and records.

16 (3) The expenses incurred in any performance examination
17 authorized by law shall be paid by the company or person being
18 examined. The charge shall be reasonably related to the cost
19 of the examination including but not limited to compensation
20 of examiners, electronic data processing costs, supervision
21 and preparation of an examination report and lodging and
22 travel expenses. All lodging and travel expenses shall be in
23 accord with the applicable travel regulations as published by
24 the Department of Central Management Services and approved by
25 the Governor's Travel Control Board, except that out-of-state
26 lodging and travel expenses related to examinations authorized

1 under Section 132 shall be in accordance with travel rates
2 prescribed under paragraph 301-7.2 of the Federal Travel
3 Regulations, 41 C.F.R. 301-7.2, for reimbursement of
4 subsistence expenses incurred during official travel. All
5 lodging and travel expenses may be reimbursed directly upon
6 authorization of the Director. With the exception of the
7 direct reimbursements authorized by the Director, all
8 performance examination charges collected by the Department
9 shall be paid to the Insurance Producer Administration Fund,
10 however, the electronic data processing costs incurred by the
11 Department in the performance of any examination shall be
12 billed directly to the company being examined for payment to
13 the Technology Management Revolving Fund.

14 (4) At the time of any service of process on the Director
15 as attorney for such service, the Director shall charge and
16 collect the sum of \$40 ~~\$20~~, which may be recovered as taxable
17 costs by the party to the suit or action causing such service
18 to be made if he prevails in such suit or action.

19 (5) (a) The costs incurred by the Department of Insurance
20 in conducting any hearing authorized by law shall be assessed
21 against the parties to the hearing in such proportion as the
22 Director of Insurance may determine upon consideration of all
23 relevant circumstances including: (1) the nature of the
24 hearing; (2) whether the hearing was instigated by, or for the
25 benefit of a particular party or parties; (3) whether there is
26 a successful party on the merits of the proceeding; and (4) the

1 relative levels of participation by the parties.

2 (b) For purposes of this subsection (5) costs incurred
3 shall mean the hearing officer fees, court reporter fees, and
4 travel expenses of Department of Insurance officers and
5 employees; provided however, that costs incurred shall not
6 include hearing officer fees or court reporter fees unless the
7 Department has retained the services of independent
8 contractors or outside experts to perform such functions.

9 (c) The Director shall make the assessment of costs
10 incurred as part of the final order or decision arising out of
11 the proceeding; provided, however, that such order or decision
12 shall include findings and conclusions in support of the
13 assessment of costs. This subsection (5) shall not be
14 construed as permitting the payment of travel expenses unless
15 calculated in accordance with the applicable travel
16 regulations of the Department of Central Management Services,
17 as approved by the Governor's Travel Control Board. The
18 Director as part of such order or decision shall require all
19 assessments for hearing officer fees and court reporter fees,
20 if any, to be paid directly to the hearing officer or court
21 reporter by the party(s) assessed for such costs. The
22 assessments for travel expenses of Department officers and
23 employees shall be reimbursable to the Director of Insurance
24 for deposit to the fund out of which those expenses had been
25 paid.

26 (d) The provisions of this subsection (5) shall apply in

1 the case of any hearing conducted by the Director of Insurance
2 not otherwise specifically provided for by law.

3 (6) The Director shall charge and collect an annual
4 financial regulation fee from every domestic company for
5 examination and analysis of its financial condition and to
6 fund the internal costs and expenses of the Interstate
7 Insurance Receivership Commission as may be allocated to the
8 State of Illinois and companies doing an insurance business in
9 this State pursuant to Article X of the Interstate Insurance
10 Receivership Compact. The fee shall be the greater fixed
11 amount based upon the combination of nationwide direct premium
12 income and nationwide reinsurance assumed premium income or
13 upon admitted assets calculated under this subsection as
14 follows:

15 (a) Combination of nationwide direct premium income
16 and nationwide reinsurance assumed premium.

17 (i) \$150, if the premium is less than \$500,000 and
18 there is no reinsurance assumed premium;

19 (ii) \$750, if the premium is \$500,000 or more, but
20 less than \$5,000,000 and there is no reinsurance
21 assumed premium; or if the premium is less than
22 \$5,000,000 and the reinsurance assumed premium is less
23 than \$10,000,000;

24 (iii) \$3,750, if the premium is less than
25 \$5,000,000 and the reinsurance assumed premium is
26 \$10,000,000 or more;

1 (iv) \$7,500, if the premium is \$5,000,000 or more,
2 but less than \$10,000,000;

3 (v) \$18,000, if the premium is \$10,000,000 or
4 more, but less than \$25,000,000;

5 (vi) \$22,500, if the premium is \$25,000,000 or
6 more, but less than \$50,000,000;

7 (vii) \$30,000, if the premium is \$50,000,000 or
8 more, but less than \$100,000,000;

9 (viii) \$37,500, if the premium is \$100,000,000 or
10 more.

11 (b) Admitted assets.

12 (i) \$150, if admitted assets are less than
13 \$1,000,000;

14 (ii) \$750, if admitted assets are \$1,000,000 or
15 more, but less than \$5,000,000;

16 (iii) \$3,750, if admitted assets are \$5,000,000 or
17 more, but less than \$25,000,000;

18 (iv) \$7,500, if admitted assets are \$25,000,000 or
19 more, but less than \$50,000,000;

20 (v) \$18,000, if admitted assets are \$50,000,000 or
21 more, but less than \$100,000,000;

22 (vi) \$22,500, if admitted assets are \$100,000,000
23 or more, but less than \$500,000,000;

24 (vii) \$30,000, if admitted assets are \$500,000,000
25 or more, but less than \$1,000,000,000;

26 (viii) \$37,500, if admitted assets are

1 \$1,000,000,000 or more.

2 (c) The sum of financial regulation fees charged to
3 the domestic companies of the same affiliated group shall
4 not exceed \$250,000 in the aggregate in any single year
5 and shall be billed by the Director to the member company
6 designated by the group.

7 (7) The Director shall charge and collect an annual
8 financial regulation fee from every foreign or alien company,
9 except fraternal benefit societies, for the examination and
10 analysis of its financial condition and to fund the internal
11 costs and expenses of the Interstate Insurance Receivership
12 Commission as may be allocated to the State of Illinois and
13 companies doing an insurance business in this State pursuant
14 to Article X of the Interstate Insurance Receivership Compact.
15 The fee shall be a fixed amount based upon Illinois direct
16 premium income and nationwide reinsurance assumed premium
17 income in accordance with the following schedule:

18 (a) \$150, if the premium is less than \$500,000 and
19 there is no reinsurance assumed premium;

20 (b) \$750, if the premium is \$500,000 or more, but less
21 than \$5,000,000 and there is no reinsurance assumed
22 premium; or if the premium is less than \$5,000,000 and the
23 reinsurance assumed premium is less than \$10,000,000;

24 (c) \$3,750, if the premium is less than \$5,000,000 and
25 the reinsurance assumed premium is \$10,000,000 or more;

26 (d) \$7,500, if the premium is \$5,000,000 or more, but

1 less than \$10,000,000;

2 (e) \$18,000, if the premium is \$10,000,000 or more,
3 but less than \$25,000,000;

4 (f) \$22,500, if the premium is \$25,000,000 or more,
5 but less than \$50,000,000;

6 (g) \$30,000, if the premium is \$50,000,000 or more,
7 but less than \$100,000,000;

8 (h) \$37,500, if the premium is \$100,000,000 or more.

9 The sum of financial regulation fees under this subsection
10 (7) charged to the foreign or alien companies within the same
11 affiliated group shall not exceed \$250,000 in the aggregate in
12 any single year and shall be billed by the Director to the
13 member company designated by the group.

14 (8) Beginning January 1, 1992, the financial regulation
15 fees imposed under subsections (6) and (7) of this Section
16 shall be paid by each company or domestic affiliated group
17 annually. After January 1, 1994, the fee shall be billed by
18 Department invoice based upon the company's premium income or
19 admitted assets as shown in its annual statement for the
20 preceding calendar year. The invoice is due upon receipt and
21 must be paid no later than June 30 of each calendar year. All
22 financial regulation fees collected by the Department shall be
23 paid to the Insurance Financial Regulation Fund. The
24 Department may not collect financial examiner per diem charges
25 from companies subject to subsections (6) and (7) of this
26 Section undergoing financial examination after June 30, 1992.

1 (9) In addition to the financial regulation fee required
2 by this Section, a company undergoing any financial
3 examination authorized by law shall pay the following costs
4 and expenses incurred by the Department: electronic data
5 processing costs, the expenses authorized under Section 131.21
6 and subsection (d) of Section 132.4 of this Code, and lodging
7 and travel expenses.

8 Electronic data processing costs incurred by the
9 Department in the performance of any examination shall be
10 billed directly to the company undergoing examination for
11 payment to the Technology Management Revolving Fund. Except
12 for direct reimbursements authorized by the Director or direct
13 payments made under Section 131.21 or subsection (d) of
14 Section 132.4 of this Code, all financial regulation fees and
15 all financial examination charges collected by the Department
16 shall be paid to the Insurance Financial Regulation Fund.

17 All lodging and travel expenses shall be in accordance
18 with applicable travel regulations published by the Department
19 of Central Management Services and approved by the Governor's
20 Travel Control Board, except that out-of-state lodging and
21 travel expenses related to examinations authorized under
22 Sections 132.1 through 132.7 shall be in accordance with
23 travel rates prescribed under paragraph 301-7.2 of the Federal
24 Travel Regulations, 41 C.F.R. 301-7.2, for reimbursement of
25 subsistence expenses incurred during official travel. All
26 lodging and travel expenses may be reimbursed directly upon

1 the authorization of the Director.

2 In the case of an organization or person not subject to the
3 financial regulation fee, the expenses incurred in any
4 financial examination authorized by law shall be paid by the
5 organization or person being examined. The charge shall be
6 reasonably related to the cost of the examination including,
7 but not limited to, compensation of examiners and other costs
8 described in this subsection.

9 (10) Any company, person, or entity failing to make any
10 payment of \$150 or more as required under this Section shall be
11 subject to the penalty and interest provisions provided for in
12 subsections (4) and (7) of Section 412.

13 (11) Unless otherwise specified, all of the fees collected
14 under this Section shall be paid into the Insurance Financial
15 Regulation Fund.

16 (12) For purposes of this Section:

17 (a) "Domestic company" means a company as defined in
18 Section 2 of this Code which is incorporated or organized
19 under the laws of this State, and in addition includes a
20 not-for-profit corporation authorized under the Dental
21 Service Plan Act or the Voluntary Health Services Plans
22 Act, a health maintenance organization, and a limited
23 health service organization.

24 (b) "Foreign company" means a company as defined in
25 Section 2 of this Code which is incorporated or organized
26 under the laws of any state of the United States other than

1 this State and in addition includes a health maintenance
2 organization and a limited health service organization
3 which is incorporated or organized under the laws of any
4 state of the United States other than this State.

5 (c) "Alien company" means a company as defined in
6 Section 2 of this Code which is incorporated or organized
7 under the laws of any country other than the United
8 States.

9 (d) "Fraternal benefit society" means a corporation,
10 society, order, lodge or voluntary association as defined
11 in Section 282.1 of this Code.

12 (e) "Mutual benefit association" means a company,
13 association or corporation authorized by the Director to
14 do business in this State under the provisions of Article
15 XVIII of this Code.

16 (f) "Burial society" means a person, firm,
17 corporation, society or association of individuals
18 authorized by the Director to do business in this State
19 under the provisions of Article XIX of this Code.

20 (g) "Farm mutual" means a district, county and
21 township mutual insurance company authorized by the
22 Director to do business in this State under the provisions
23 of the Farm Mutual Insurance Company Act of 1986.

24 (Source: P.A. 100-23, eff. 7-6-17.)

25 (215 ILCS 5/412) (from Ch. 73, par. 1024)

1 Sec. 412. Refunds; penalties; collection.

2 (1) (a) Whenever it appears to the satisfaction of the
3 Director that because of some mistake of fact, error in
4 calculation, or erroneous interpretation of a statute of this
5 or any other state, any authorized company, surplus line
6 producer, or industrial insured has paid to him, pursuant to
7 any provision of law, taxes, fees, or other charges in excess
8 of the amount legally chargeable against it, during the 6 year
9 period immediately preceding the discovery of such
10 overpayment, he shall have power to refund to such company,
11 surplus line producer, or industrial insured the amount of the
12 excess or excesses by applying the amount or amounts thereof
13 toward the payment of taxes, fees, or other charges already
14 due, or which may thereafter become due from that company
15 until such excess or excesses have been fully refunded, or
16 upon a written request from the authorized company, surplus
17 line producer, or industrial insured, the Director shall
18 provide a cash refund within 120 days after receipt of the
19 written request if all necessary information has been filed
20 with the Department in order for it to perform an audit of the
21 tax report for the transaction or period or annual return for
22 the year in which the overpayment occurred or within 120 days
23 after the date the Department receives all the necessary
24 information to perform such audit. The Director shall not
25 provide a cash refund if there are insufficient funds in the
26 Insurance Premium Tax Refund Fund to provide a cash refund, if

1 the amount of the overpayment is less than \$100, or if the
2 amount of the overpayment can be fully offset against the
3 taxpayer's estimated liability for the year following the year
4 of the cash refund request. Any cash refund shall be paid from
5 the Insurance Premium Tax Refund Fund, a special fund hereby
6 created in the State treasury.

7 (b) As determined by the Director pursuant to paragraph
8 (a) of this subsection ~~Beginning January 1, 2000 and~~
9 ~~thereafter~~, the Department shall deposit an amount of cash
10 refunds approved by the Director for payment as a result of
11 overpayment of tax liability ~~a percentage of the amounts~~
12 collected under Sections 121-2.08, 409, 444, and 444.1, and
13 445 of this Code into the Insurance Premium Tax Refund Fund.
14 ~~The percentage deposited into the Insurance Premium Tax Refund~~
15 ~~Fund shall be the annual percentage. The annual percentage~~
16 ~~shall be calculated as a fraction, the numerator of which~~
17 ~~shall be the amount of cash refunds approved by the Director~~
18 ~~for payment and paid during the preceding calendar year as a~~
19 ~~result of overpayment of tax liability under Sections~~
20 ~~121-2.08, 409, 444, 444.1, and 445 of this Code and the~~
21 ~~denominator of which shall be the amounts collected pursuant~~
22 ~~to Sections 121-2.08, 409, 444, 444.1, and 445 of this Code~~
23 ~~during the preceding calendar year. However, if there were no~~
24 ~~cash refunds paid in a preceding calendar year, the Department~~
25 ~~shall deposit 5% of the amount collected in that preceding~~
26 ~~calendar year pursuant to Sections 121-2.08, 409, 444, 444.1,~~

1 ~~and 445 of this Code into the Insurance Premium Tax Refund Fund~~
2 ~~instead of an amount calculated by using the annual~~
3 ~~percentage.~~

4 (c) Beginning July 1, 1999, moneys in the Insurance
5 Premium Tax Refund Fund shall be expended exclusively for the
6 purpose of paying cash refunds resulting from overpayment of
7 tax liability under Sections 121-2.08, 409, 444, 444.1, and
8 445 of this Code as determined by the Director pursuant to
9 subsection 1(a) of this Section. Cash refunds made in
10 accordance with this Section may be made from the Insurance
11 Premium Tax Refund Fund only to the extent that amounts have
12 been deposited and retained in the Insurance Premium Tax
13 Refund Fund.

14 (d) This Section shall constitute an irrevocable and
15 continuing appropriation from the Insurance Premium Tax Refund
16 Fund for the purpose of paying cash refunds pursuant to the
17 provisions of this Section.

18 (2)(a) When any insurance company fails to file any tax
19 return required under Sections 408.1, 409, 444, and 444.1 of
20 this Code or Section 12 of the Fire Investigation Act on the
21 date prescribed, including any extensions, there shall be
22 added as a penalty \$400 or 10% of the amount of such tax,
23 whichever is greater, for each month or part of a month of
24 failure to file, the entire penalty not to exceed \$2,000 or 50%
25 of the tax due, whichever is greater.

26 (b) When any industrial insured or surplus line producer

1 fails to file any tax return or report required under Sections
2 121-2.08 and 445 of this Code or Section 12 of the Fire
3 Investigation Act on the date prescribed, including any
4 extensions, there shall be added:

5 (i) as a late fee, if the return or report is received
6 at least one day but not more than 7 days after the
7 prescribed due date, \$400 or 10% of the tax due, whichever
8 is greater, the entire fee not to exceed \$1,000;

9 (ii) as a late fee, if the return or report is received
10 at least 8 days but not more than 14 days after the
11 prescribed due date, \$400 or 10% of the tax due, whichever
12 is greater, the entire fee not to exceed \$1,500;

13 (iii) as a late fee, if the return or report is
14 received at least 15 days but not more than 21 days after
15 the prescribed due date, \$400 or 10% of the tax due,
16 whichever is greater, the entire fee not to exceed \$2,000;
17 or

18 (iv) as a penalty, if the return or report is received
19 more than 21 days after the prescribed due date, \$400 or
20 10% of the tax due, whichever is greater, for each month or
21 part of a month of failure to file, the entire penalty not
22 to exceed \$2,000 or 50% of the tax due, whichever is
23 greater.

24 A tax return or report shall be deemed received as of the
25 date mailed as evidenced by a postmark, proof of mailing on a
26 recognized United States Postal Service form or a form

1 acceptable to the United States Postal Service or other
2 commercial mail delivery service, or other evidence acceptable
3 to the Director.

4 (3)(a) When any insurance company fails to pay the full
5 amount due under the provisions of this Section, Sections
6 408.1, 409, 444, or 444.1 of this Code, or Section 12 of the
7 Fire Investigation Act, there shall be added to the amount due
8 as a penalty an amount equal to 10% of the deficiency.

9 (a-5) When any industrial insured or surplus line producer
10 fails to pay the full amount due under the provisions of this
11 Section, Sections 121-2.08 or 445 of this Code, or Section 12
12 of the Fire Investigation Act on the date prescribed, there
13 shall be added:

14 (i) as a late fee, if the payment is received at least
15 one day but not more than 7 days after the prescribed due
16 date, 10% of the tax due, the entire fee not to exceed
17 \$1,000;

18 (ii) as a late fee, if the payment is received at least
19 8 days but not more than 14 days after the prescribed due
20 date, 10% of the tax due, the entire fee not to exceed
21 \$1,500;

22 (iii) as a late fee, if the payment is received at
23 least 15 days but not more than 21 days after the
24 prescribed due date, 10% of the tax due, the entire fee not
25 to exceed \$2,000; or

26 (iv) as a penalty, if the return or report is received

1 more than 21 days after the prescribed due date, 10% of the
2 tax due.

3 A tax payment shall be deemed received as of the date
4 mailed as evidenced by a postmark, proof of mailing on a
5 recognized United States Postal Service form or a form
6 acceptable to the United States Postal Service or other
7 commercial mail delivery service, or other evidence acceptable
8 to the Director.

9 (b) If such failure to pay is determined by the Director to
10 be wilful, after a hearing under Sections 402 and 403, there
11 shall be added to the tax as a penalty an amount equal to the
12 greater of 50% of the deficiency or 10% of the amount due and
13 unpaid for each month or part of a month that the deficiency
14 remains unpaid commencing with the date that the amount
15 becomes due. Such amount shall be in lieu of any determined
16 under paragraph (a) or (a-5).

17 (4) Any insurance company, industrial insured, or surplus
18 line producer that fails to pay the full amount due under this
19 Section or Sections 121-2.08, 408.1, 409, 444, 444.1, or 445
20 of this Code, or Section 12 of the Fire Investigation Act is
21 liable, in addition to the tax and any late fees and penalties,
22 for interest on such deficiency at the rate of 12% per annum,
23 or at such higher adjusted rates as are or may be established
24 under subsection (b) of Section 6621 of the Internal Revenue
25 Code, from the date that payment of any such tax was due,
26 determined without regard to any extensions, to the date of

1 payment of such amount.

2 (5) The Director, through the Attorney General, may
3 institute an action in the name of the People of the State of
4 Illinois, in any court of competent jurisdiction, for the
5 recovery of the amount of such taxes, fees, and penalties due,
6 and prosecute the same to final judgment, and take such steps
7 as are necessary to collect the same.

8 (6) In the event that the certificate of authority of a
9 foreign or alien company is revoked for any cause or the
10 company withdraws from this State prior to the renewal date of
11 the certificate of authority as provided in Section 114, the
12 company may recover the amount of any such tax paid in advance.
13 Except as provided in this subsection, no revocation or
14 withdrawal excuses payment of or constitutes grounds for the
15 recovery of any taxes or penalties imposed by this Code.

16 (7) When an insurance company or domestic affiliated group
17 fails to pay the full amount of any fee of \$200 or more due
18 under Section 408 of this Code, there shall be added to the
19 amount due as a penalty the greater of \$100 or an amount equal
20 to 10% of the deficiency for each month or part of a month that
21 the deficiency remains unpaid.

22 (8) The Department shall have a lien for the taxes, fees,
23 charges, fines, penalties, interest, other charges, or any
24 portion thereof, imposed or assessed pursuant to this Code,
25 upon all the real and personal property of any company or
26 person to whom the assessment or final order has been issued or

1 whenever a tax return is filed without payment of the tax or
2 penalty shown therein to be due, including all such property
3 of the company or person acquired after receipt of the
4 assessment, issuance of the order, or filing of the return.
5 The company or person is liable for the filing fee incurred by
6 the Department for filing the lien and the filing fee incurred
7 by the Department to file the release of that lien. The filing
8 fees shall be paid to the Department in addition to payment of
9 the tax, fee, charge, fine, penalty, interest, other charges,
10 or any portion thereof, included in the amount of the lien.
11 However, where the lien arises because of the issuance of a
12 final order of the Director or tax assessment by the
13 Department, the lien shall not attach and the notice referred
14 to in this Section shall not be filed until all administrative
15 proceedings or proceedings in court for review of the final
16 order or assessment have terminated or the time for the taking
17 thereof has expired without such proceedings being instituted.

18 Upon the granting of Department review after a lien has
19 attached, the lien shall remain in full force except to the
20 extent to which the final assessment may be reduced by a
21 revised final assessment following the rehearing or review.
22 The lien created by the issuance of a final assessment shall
23 terminate, unless a notice of lien is filed, within 3 years
24 after the date all proceedings in court for the review of the
25 final assessment have terminated or the time for the taking
26 thereof has expired without such proceedings being instituted,

1 or (in the case of a revised final assessment issued pursuant
2 to a rehearing or review by the Department) within 3 years
3 after the date all proceedings in court for the review of such
4 revised final assessment have terminated or the time for the
5 taking thereof has expired without such proceedings being
6 instituted. Where the lien results from the filing of a tax
7 return without payment of the tax or penalty shown therein to
8 be due, the lien shall terminate, unless a notice of lien is
9 filed, within 3 years after the date when the return is filed
10 with the Department.

11 The time limitation period on the Department's right to
12 file a notice of lien shall not run during any period of time
13 in which the order of any court has the effect of enjoining or
14 restraining the Department from filing such notice of lien. If
15 the Department finds that a company or person is about to
16 depart from the State, to conceal himself or his property, or
17 to do any other act tending to prejudice or to render wholly or
18 partly ineffectual proceedings to collect the amount due and
19 owing to the Department unless such proceedings are brought
20 without delay, or if the Department finds that the collection
21 of the amount due from any company or person will be
22 jeopardized by delay, the Department shall give the company or
23 person notice of such findings and shall make demand for
24 immediate return and payment of the amount, whereupon the
25 amount shall become immediately due and payable. If the
26 company or person, within 5 days after the notice (or within

1 such extension of time as the Department may grant), does not
2 comply with the notice or show to the Department that the
3 findings in the notice are erroneous, the Department may file
4 a notice of jeopardy assessment lien in the office of the
5 recorder of the county in which any property of the company or
6 person may be located and shall notify the company or person of
7 the filing. The jeopardy assessment lien shall have the same
8 scope and effect as the statutory lien provided for in this
9 Section. If the company or person believes that the company or
10 person does not owe some or all of the tax for which the
11 jeopardy assessment lien against the company or person has
12 been filed, or that no jeopardy to the revenue in fact exists,
13 the company or person may protest within 20 days after being
14 notified by the Department of the filing of the jeopardy
15 assessment lien and request a hearing, whereupon the
16 Department shall hold a hearing in conformity with the
17 provisions of this Code and, pursuant thereto, shall notify
18 the company or person of its findings as to whether or not the
19 jeopardy assessment lien will be released. If not, and if the
20 company or person is aggrieved by this decision, the company
21 or person may file an action for judicial review of the final
22 determination of the Department in accordance with the
23 Administrative Review Law. If, pursuant to such hearing (or
24 after an independent determination of the facts by the
25 Department without a hearing), the Department determines that
26 some or all of the amount due covered by the jeopardy

1 assessment lien is not owed by the company or person, or that
2 no jeopardy to the revenue exists, or if on judicial review the
3 final judgment of the court is that the company or person does
4 not owe some or all of the amount due covered by the jeopardy
5 assessment lien against them, or that no jeopardy to the
6 revenue exists, the Department shall release its jeopardy
7 assessment lien to the extent of such finding of nonliability
8 for the amount, or to the extent of such finding of no jeopardy
9 to the revenue. The Department shall also release its jeopardy
10 assessment lien against the company or person whenever the
11 amount due and owing covered by the lien, plus any interest
12 which may be due, are paid and the company or person has paid
13 the Department in cash or by guaranteed remittance an amount
14 representing the filing fee for the lien and the filing fee for
15 the release of that lien. The Department shall file that
16 release of lien with the recorder of the county where that lien
17 was filed.

18 Nothing in this Section shall be construed to give the
19 Department a preference over the rights of any bona fide
20 purchaser, holder of a security interest, mechanics
21 lienholder, mortgagee, or judgment lien creditor arising prior
22 to the filing of a regular notice of lien or a notice of
23 jeopardy assessment lien in the office of the recorder in the
24 county in which the property subject to the lien is located.
25 For purposes of this Section, "bona fide" shall not include
26 any mortgage of real or personal property or any other credit

1 transaction that results in the mortgagee or the holder of the
2 security acting as trustee for unsecured creditors of the
3 company or person mentioned in the notice of lien who executed
4 such chattel or real property mortgage or the document
5 evidencing such credit transaction. The lien shall be inferior
6 to the lien of general taxes, special assessments, and special
7 taxes levied by any political subdivision of this State. In
8 case title to land to be affected by the notice of lien or
9 notice of jeopardy assessment lien is registered under the
10 provisions of the Registered Titles (Torrens) Act, such notice
11 shall be filed in the office of the Registrar of Titles of the
12 county within which the property subject to the lien is
13 situated and shall be entered upon the register of titles as a
14 memorial or charge upon each folium of the register of titles
15 affected by such notice, and the Department shall not have a
16 preference over the rights of any bona fide purchaser,
17 mortgagee, judgment creditor, or other lienholder arising
18 prior to the registration of such notice. The regular lien or
19 jeopardy assessment lien shall not be effective against any
20 purchaser with respect to any item in a retailer's stock in
21 trade purchased from the retailer in the usual course of the
22 retailer's business.

23 (Source: P.A. 98-158, eff. 8-2-13; 98-978, eff. 1-1-15.)

24 (215 ILCS 5/416)

25 Sec. 416. Illinois Workers' Compensation Commission

1 Operations Fund Surcharge.

2 (a) As of July 30, 2004 (the effective date of Public Act
3 93-840), every company licensed or authorized by the Illinois
4 Department of Insurance and insuring employers' liabilities
5 arising under the Workers' Compensation Act or the Workers'
6 Occupational Diseases Act shall remit to the Director a
7 surcharge based upon the annual direct written premium, as
8 reported under Section 136 of this Act, of the company in the
9 manner provided in this Section. Such proceeds shall be
10 deposited into the Illinois Workers' Compensation Commission
11 Operations Fund as established in the Workers' Compensation
12 Act. If a company survives or was formed by a merger,
13 consolidation, reorganization, or reincorporation, the direct
14 written premiums of all companies party to the merger,
15 consolidation, reorganization, or reincorporation shall, for
16 purposes of determining the amount of the fee imposed by this
17 Section, be regarded as those of the surviving or new company.

18 (b) (1) Except as provided in subsection (b) (2) of this
19 Section, beginning on July 30, 2004 (the effective date of
20 Public Act 93-840) and on July 1 of each year thereafter, the
21 Director shall charge an annual Illinois Workers' Compensation
22 Commission Operations Fund Surcharge from every company
23 subject to subsection (a) of this Section equal to 1.01% of its
24 direct written premium for insuring employers' liabilities
25 arising under the Workers' Compensation Act or Workers'
26 Occupational Diseases Act as reported in each company's annual

1 statement filed for the previous year as required by Section
2 136. The Illinois Workers' Compensation Commission Operations
3 Fund Surcharge shall be collected by companies subject to
4 subsection (a) of this Section as a separately stated
5 surcharge on insured employers at the rate of 1.01% of direct
6 written premium. The Illinois Workers' Compensation Commission
7 Operations Fund Surcharge shall not be collected by companies
8 subject to subsection (a) of this Section from any employer
9 that self-insures its liabilities arising under the Workers'
10 Compensation Act or Workers' Occupational Diseases Act,
11 provided that the employer has paid the Illinois Workers'
12 Compensation Commission Operations Fund Fee pursuant to
13 Section 4d of the Workers' Compensation Act. All sums
14 collected by the Department of Insurance under the provisions
15 of this Section shall be paid promptly after the receipt of the
16 same, accompanied by a detailed statement thereof, into the
17 Illinois Workers' Compensation Commission Operations Fund in
18 the State treasury.

19 (b) (2) The surcharge due pursuant to Public Act 93-840
20 shall be collected instead of the surcharge due on July 1, 2004
21 under Public Act 93-32. Payment of the surcharge due under
22 Public Act 93-840 shall discharge the employer's obligations
23 due on July 1, 2004.

24 (c) In addition to the authority specifically granted
25 under Article XXV of this Code, the Director shall have such
26 authority to adopt rules or establish forms as may be

1 reasonably necessary for purposes of enforcing this Section.
2 The Director shall also have authority to defer, waive, or
3 abate the surcharge or any penalties imposed by this Section
4 if in the Director's opinion the company's solvency and
5 ability to meet its insured obligations would be immediately
6 threatened by payment of the surcharge due.

7 (d) When a company fails to pay the full amount of any
8 annual Illinois Workers' Compensation Commission Operations
9 Fund Surcharge of \$100 or more due under this Section, there
10 shall be added to the amount due as a penalty ~~the greater of~~
11 ~~\$1,000 or~~ an amount equal to 10% ~~5%~~ of the deficiency for each
12 month or part of a month that the deficiency remains unpaid.

13 (e) The Department of Insurance may enforce the collection
14 of any delinquent payment, penalty, or portion thereof by
15 legal action or in any other manner by which the collection of
16 debts due the State of Illinois may be enforced under the laws
17 of this State.

18 (f) Whenever it appears to the satisfaction of the
19 Director that a company has paid pursuant to this Act an
20 Illinois Workers' Compensation Commission Operations Fund
21 Surcharge in an amount in excess of the amount legally
22 collectable from the company, the Director shall issue a
23 credit memorandum for an amount equal to the amount of such
24 overpayment. A credit memorandum may be applied for the 2-year
25 period from the date of issuance, against the payment of any
26 amount due during that period under the surcharge imposed by

1 this Section or, subject to reasonable rule of the Department
2 of Insurance including requirement of notification, may be
3 assigned to any other company subject to regulation under this
4 Act. Any application of credit memoranda after the period
5 provided for in this Section is void.

6 (g) Annually, the Governor may direct a transfer of up to
7 2% of all moneys collected under this Section to the Insurance
8 Financial Regulation Fund.

9 (Source: P.A. 95-331, eff. 8-21-07.)

10 (215 ILCS 5/356z.27 rep.)

11 Section 15. The Illinois Insurance Code is amended by
12 repealing Section 356z.27.

13 Section 20. The Illinois Health Insurance Portability and
14 Accountability Act is amended by changing Section 20 as
15 follows:

16 (215 ILCS 97/20)

17 Sec. 20. Increased portability through prohibition of
18 ~~limitation on~~ preexisting condition exclusions.

19 (A) No health insurance coverage issued, amended,
20 delivered, or renewed on or after the effective date of this
21 amendatory Act of the 102nd General Assembly may impose any
22 preexisting condition exclusion with respect to the plan or
23 coverage. This provision does not apply to the provision of

1 ~~excepted benefits as described in paragraph (2) of subsection~~
2 ~~(C). Limitation of preexisting condition exclusion period;~~
3 ~~crediting for periods of previous coverage. Subject to~~
4 ~~subsection (D), a group health plan, and a health insurance~~
5 ~~issuer offering group health insurance coverage, may, with~~
6 ~~respect to a participant or beneficiary, impose a preexisting~~
7 ~~condition exclusion only if:~~

8 ~~(1) the exclusion relates to a condition (whether~~
9 ~~physical or mental), regardless of the cause of the~~
10 ~~condition, for which medical advice, diagnosis, care, or~~
11 ~~treatment was recommended or received within the 6-month~~
12 ~~period ending on the enrollment date;~~

13 ~~(2) the exclusion extends for a period of not more~~
14 ~~than 12 months (or 18 months in the case of a late~~
15 ~~enrollee) after the enrollment date; and~~

16 ~~(3) the period of any such preexisting condition~~
17 ~~exclusion is reduced by the aggregate of the periods of~~
18 ~~creditable coverage (if any, as defined in subsection~~
19 ~~(C)(1)) applicable to the participant or beneficiary as of~~
20 ~~the enrollment date.~~

21 (B) (Blank). ~~Preexisting condition exclusion. A group~~
22 ~~health plan, and health insurance issuer offering group health~~
23 ~~insurance coverage, may not impose any preexisting condition~~
24 ~~exclusion relating to pregnancy as a preexisting condition.~~

25 ~~Genetic information shall not be treated as a condition~~
26 ~~described in subsection (A)(1) in the absence of a diagnosis~~

1 ~~of the condition related to such information.~~

2 (C) Rules relating to crediting previous coverage.

3 (1) Creditable coverage defined. For purposes of this
4 Act, the term "creditable coverage" means, with respect to
5 an individual, coverage of the individual under any of the
6 following:

7 (a) A group health plan.

8 (b) Health insurance coverage.

9 (c) Part A or part B of title XVIII of the Social
10 Security Act.

11 (d) Title XIX of the Social Security Act, other
12 than coverage consisting solely of benefits under
13 Section 1928.

14 (e) Chapter 55 of title 10, United States Code.

15 (f) A medical care program of the Indian Health
16 Service or of a tribal organization.

17 (g) A State health benefits risk pool.

18 (h) A health plan offered under chapter 89 of
19 title 5, United States Code.

20 (i) A public health plan (as defined in
21 regulations).

22 (j) A health benefit plan under Section 5(e) of
23 the Peace Corps Act (22 U.S.C. 2504(e)).

24 (k) Title XXI of the federal Social Security Act,
25 State Children's Health Insurance Program.

26 Such term does not include coverage consisting solely

1 of coverage of excepted benefits.

2 (2) Excepted benefits. For purposes of this Act, the
3 term "excepted benefits" means benefits under one or more
4 of the following:

5 (a) Benefits not subject to requirements:

6 (i) Coverage only for accident, or disability
7 income insurance, or any combination thereof.

8 (ii) Coverage issued as a supplement to
9 liability insurance.

10 (iii) Liability insurance, including general
11 liability insurance and automobile liability
12 insurance.

13 (iv) Workers' compensation or similar
14 insurance.

15 (v) Automobile medical payment insurance.

16 (vi) Credit-only insurance.

17 (vii) Coverage for on-site medical clinics.

18 (viii) Other similar insurance coverage,
19 specified in regulations, under which benefits for
20 medical care are secondary or incidental to other
21 insurance benefits.

22 (b) Benefits not subject to requirements if
23 offered separately:

24 (i) Limited scope dental or vision benefits.

25 (ii) Benefits for long-term care, nursing home
26 care, home health care, community-based care, or

1 any combination thereof.

2 (iii) Such other similar, limited benefits as
3 are specified in rules.

4 (c) Benefits not subject to requirements if
5 offered, as independent, noncoordinated benefits:

6 (i) Coverage only for a specified disease or
7 illness.

8 (ii) Hospital indemnity or other fixed
9 indemnity insurance.

10 (d) Benefits not subject to requirements if
11 offered as separate insurance policy. Medicare
12 supplemental health insurance (as defined under
13 Section 1882(g)(1) of the Social Security Act),
14 coverage supplemental to the coverage provided under
15 chapter 55 of title 10, United States Code, and
16 similar supplemental coverage provided to coverage
17 under a group health plan.

18 (3) Not counting periods before significant breaks in
19 coverage.

20 (a) In general. A period of creditable coverage
21 shall not be counted, with respect to enrollment of an
22 individual under a group health plan, if, after such
23 period and before the enrollment date, there was a
24 63-day period during all of which the individual was
25 not covered under any creditable coverage.

26 (b) Waiting period not treated as a break in

1 coverage. For purposes of subparagraph (a) and
2 subsection (D) (3), any period that an individual is in
3 a waiting period for any coverage under a group health
4 plan (or for group health insurance coverage) or is in
5 an affiliation period (as defined in subsection
6 (G) (2)) shall not be taken into account in determining
7 the continuous period under subparagraph (a).

8 (4) (Blank). ~~Method of crediting coverage.~~

9 ~~(a) Standard method. Except as otherwise provided~~
10 ~~under subparagraph (b), for purposes of applying~~
11 ~~subsection (A) (3), a group health plan, and a health~~
12 ~~insurance issuer offering group health insurance~~
13 ~~coverage, shall count a period of creditable coverage~~
14 ~~without regard to the specific benefits covered during~~
15 ~~the period.~~

16 ~~(b) Election of alternative method. A group health~~
17 ~~plan, or a health insurance issuer offering group~~
18 ~~health insurance, may elect to apply subsection (A) (3)~~
19 ~~based on coverage of benefits within each of several~~
20 ~~classes or categories of benefits specified in~~
21 ~~regulations rather than as provided under subparagraph~~
22 ~~(a). Such election shall be made on a uniform basis for~~
23 ~~all participants and beneficiaries. Under such~~
24 ~~election a group health plan or issuer shall count a~~
25 ~~period of creditable coverage with respect to any~~
26 ~~class or category of benefits if any level of benefits~~

1 ~~is covered within such class or category.~~

2 ~~(c) Plan notice. In the case of an election with~~
3 ~~respect to a group health plan under subparagraph (b)~~
4 ~~(whether or not health insurance coverage is provided~~
5 ~~in connection with such plan), the plan shall:~~

6 ~~(i) prominently state in any disclosure~~
7 ~~statements concerning the plan, and state to each~~
8 ~~enrollee at the time of enrollment under the plan,~~
9 ~~that the plan has made such election; and~~

10 ~~(ii) include in such statements a description~~
11 ~~of the effect of this election.~~

12 ~~(d) Issuer notice. In the case of an election~~
13 ~~under subparagraph (b) with respect to health~~
14 ~~insurance coverage offered by an issuer in the small~~
15 ~~or large group market, the issuer:~~

16 ~~(i) shall prominently state in any disclosure~~
17 ~~statements concerning the coverage, and to each~~
18 ~~employer at the time of the offer or sale of the~~
19 ~~coverage, that the issuer has made such election;~~
20 ~~and~~

21 ~~(ii) shall include in such statements a~~
22 ~~description of the effect of such election.~~

23 (5) Establishment of period. Periods of creditable
24 coverage with respect to an individual shall be
25 established through presentation or certifications
26 described in subsection (E) or in such other manner as may

1 be specified in regulations.

2 (D) (Blank). ~~Exceptions:~~

3 ~~(1) Exclusion not applicable to certain newborns.~~
4 ~~Subject to paragraph (3), a group health plan, and a~~
5 ~~health insurance issuer offering group health insurance~~
6 ~~coverage, may not impose any preexisting condition~~
7 ~~exclusion in the case of an individual who, as of the last~~
8 ~~day of the 30 day period beginning with the date of birth,~~
9 ~~is covered under creditable coverage.~~

10 ~~(2) Exclusion not applicable to certain adopted~~
11 ~~children. Subject to paragraph (3), a group health plan,~~
12 ~~and a health insurance issuer offering group health~~
13 ~~insurance coverage, may not impose any preexisting~~
14 ~~condition exclusion in the case of a child who is adopted~~
15 ~~or placed for adoption before attaining 18 years of age~~
16 ~~and who, as of the last day of the 30 day period beginning~~
17 ~~on the date of the adoption or placement for adoption, is~~
18 ~~covered under creditable coverage.~~

19 ~~The previous sentence shall not apply to coverage~~
20 ~~before the date of such adoption or placement for~~
21 ~~adoption.~~

22 ~~(3) Loss if break in coverage. Paragraphs (1) and (2)~~
23 ~~shall no longer apply to an individual after the end of the~~
24 ~~first 63 day period during all of which the individual was~~
25 ~~not covered under any creditable coverage.~~

26 (E) Certifications and disclosure of coverage.

1 (1) Requirement for Certification of Period of
2 Creditable Coverage.

3 (a) A group health plan, and a health insurance
4 issuer offering group health insurance coverage, shall
5 provide the certification described in subparagraph

6 (b):

7 (i) at the time an individual ceases to be
8 covered under the plan or otherwise becomes
9 covered under a COBRA continuation provision;

10 (ii) in the case of an individual becoming
11 covered under such a provision, at the time the
12 individual ceases to be covered under such
13 provision; and

14 (iii) on the request on behalf of an
15 individual made not later than 24 months after the
16 date of cessation of the coverage described in
17 clause (i) or (ii), whichever is later.

18 The certification under clause (i) may be provided, to
19 the extent practicable, at a time consistent with
20 notices required under any applicable COBRA
21 continuation provision.

22 (b) The certification described in this
23 subparagraph is a written certification of:

24 (i) the period of creditable coverage of the
25 individual under such plan and the coverage (if
26 any) under such COBRA continuation provision; and

1 (ii) the waiting period (if any) (and
2 affiliation period, if applicable) imposed with
3 respect to the individual for any coverage under
4 such plan.

5 (c) To the extent that medical care under a group
6 health plan consists of group health insurance
7 coverage, the plan is deemed to have satisfied the
8 certification requirement under this paragraph if the
9 health insurance issuer offering the coverage provides
10 for such certification in accordance with this
11 paragraph.

12 (2) (Blank). ~~Disclosure of information on previous~~
13 ~~benefits. In the case of an election described in~~
14 ~~subsection (C) (4) (b) by a group health plan or health~~
15 ~~insurance issuer, if the plan or issuer enrolls an~~
16 ~~individual for coverage under the plan and the individual~~
17 ~~provides a certification of coverage of the individual~~
18 ~~under paragraph (1):~~

19 ~~(a) upon request of such plan or issuer, the~~
20 ~~entity which issued the certification provided by the~~
21 ~~individual shall promptly disclose to such requesting~~
22 ~~plan or issuer information on coverage of classes and~~
23 ~~categories of health benefits available under such~~
24 ~~entity's plan or coverage; and~~

25 ~~(b) such entity may charge the requesting plan or~~
26 ~~issuer for the reasonable cost of disclosing such~~

1 ~~information.~~

2 (3) Rules. The Department shall establish rules to
3 prevent an entity's failure to provide information under
4 paragraph (1) ~~or (2)~~ with respect to previous coverage of
5 an individual from adversely affecting any subsequent
6 coverage of the individual under another group health plan
7 or health insurance coverage.

8 (4) Treatment of certain plans as group health plan
9 for notice provision. A program under which creditable
10 coverage described in subparagraph (c), (d), (e), or (f)
11 of Section 20(C)(1) is provided shall be treated as a
12 group health plan for purposes of this Section.

13 (F) Special enrollment periods.

14 (1) Individuals losing other coverage. A group health
15 plan, and a health insurance issuer offering group health
16 insurance coverage in connection with a group health plan,
17 shall permit an employee who is eligible, but not
18 enrolled, for coverage under the terms of the plan (or a
19 dependent of such an employee if the dependent is
20 eligible, but not enrolled, for coverage under such terms)
21 to enroll for coverage under the terms of the plan if each
22 of the following conditions is met:

23 (a) The employee or dependent was covered under a
24 group health plan or had health insurance coverage at
25 the time coverage was previously offered to the
26 employee or dependent.

1 (b) The employee stated in writing at such time
2 that coverage under a group health plan or health
3 insurance coverage was the reason for declining
4 enrollment, but only if the plan sponsor or issuer (if
5 applicable) required such a statement at such time and
6 provided the employee with notice of such requirement
7 (and the consequences of such requirement) at such
8 time.

9 (c) The employee's or dependent's coverage
10 described in subparagraph (a):

11 (i) was under a COBRA continuation provision
12 and the coverage under such provision was
13 exhausted; or

14 (ii) was not under such a provision and either
15 the coverage was terminated as a result of loss of
16 eligibility for the coverage (including as a
17 result of legal separation, divorce, death,
18 termination of employment, or reduction in the
19 number of hours of employment) or employer
20 contributions towards such coverage were
21 terminated.

22 (d) Under the terms of the plan, the employee
23 requests such enrollment not later than 30 days after
24 the date of exhaustion of coverage described in
25 subparagraph (c)(i) or termination of coverage or
26 employer contributions described in subparagraph

1 (c) (ii).

2 (2) For dependent beneficiaries.

3 (a) In general. If:

4 (i) a group health plan makes coverage
5 available with respect to a dependent of an
6 individual,

7 (ii) the individual is a participant under the
8 plan (or has met any waiting period applicable to
9 becoming a participant under the plan and is
10 eligible to be enrolled under the plan but for a
11 failure to enroll during a previous enrollment
12 period), and

13 (iii) a person becomes such a dependent of the
14 individual through marriage, birth, or adoption or
15 placement for adoption,

16 then the group health plan shall provide for a
17 dependent special enrollment period described in
18 subparagraph (b) during which the person (or, if not
19 otherwise enrolled, the individual) may be enrolled
20 under the plan as a dependent of the individual, and in
21 the case of the birth or adoption of a child, the
22 spouse of the individual may be enrolled as a
23 dependent of the individual if such spouse is
24 otherwise eligible for coverage.

25 (b) Dependent special enrollment period. A
26 dependent special enrollment period under this

1 subparagraph shall be a period of not less than 30 days
2 and shall begin on the later of:

3 (i) the date dependent coverage is made
4 available; or

5 (ii) the date of the marriage, birth, or
6 adoption or placement for adoption (as the case
7 may be) described in subparagraph (a)(iii).

8 (c) No waiting period. If an individual seeks to
9 enroll a dependent during the first 30 days of such a
10 dependent special enrollment period, the coverage of
11 the dependent shall become effective:

12 (i) in the case of marriage, not later than
13 the first day of the first month beginning after
14 the date the completed request for enrollment is
15 received;

16 (ii) in the case of a dependent's birth, as of
17 the date of such birth; or

18 (iii) in the case of a dependent's adoption or
19 placement for adoption, the date of such adoption
20 or placement for adoption.

21 (G) Use of affiliation period by HMOs as alternative to
22 preexisting condition exclusion.

23 (1) In general. A health maintenance organization
24 which offers health insurance coverage in connection with
25 a group health plan and which does not impose any
26 pre-existing condition exclusion ~~allowed under subsection~~

1 ~~(A)~~ with respect to any particular coverage option may
2 impose an affiliation period for such coverage option, but
3 only if:

4 (a) such period is applied uniformly without
5 regard to any health status-related factors; and

6 (b) such period does not exceed 2 months (or 3
7 months in the case of a late enrollee).

8 (2) Affiliation period.

9 (a) Defined. For purposes of this Act, the term
10 "affiliation period" means a period which, under the
11 terms of the health insurance coverage offered by the
12 health maintenance organization, must expire before
13 the health insurance coverage becomes effective. The
14 organization is not required to provide health care
15 services or benefits during such period and no premium
16 shall be charged to the participant or beneficiary for
17 any coverage during the period.

18 (b) Beginning. Such period shall begin on the
19 enrollment date.

20 (c) Runs concurrently with waiting periods. An
21 affiliation period under a plan shall run concurrently
22 with any waiting period under the plan.

23 (3) Alternative methods. A health maintenance
24 organization described in paragraph (1) may use
25 alternative methods, from those described in such
26 paragraph, to address adverse selection as approved by the

1 Department.

2 (Source: P.A. 90-30, eff. 7-1-97; 90-736, eff. 8-12-98.)

3 Section 25. The Health Maintenance Organization Act is
4 amended by changing Section 5-3 as follows:

5 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

6 Sec. 5-3. Insurance Code provisions.

7 (a) Health Maintenance Organizations shall be subject to
8 the provisions of Sections 133, 134, 136, 137, 139, 140,
9 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
10 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2,
11 355.3, 355b, 355c, 356g.5-1, 356m, 356q, 356v, 356w, 356x,
12 356y, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
13 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
14 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29,
15 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36,
16 356z.40, 356z.41, 356z.43, 356z.46, 356z.47, 356z.48, 356z.50,
17 356z.51, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,
18 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,
19 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
20 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
21 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
22 Illinois Insurance Code.

23 (b) For purposes of the Illinois Insurance Code, except
24 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,

1 Health Maintenance Organizations in the following categories
2 are deemed to be "domestic companies":

3 (1) a corporation authorized under the Dental Service
4 Plan Act or the Voluntary Health Services Plans Act;

5 (2) a corporation organized under the laws of this
6 State; or

7 (3) a corporation organized under the laws of another
8 state, 30% or more of the enrollees of which are residents
9 of this State, except a corporation subject to
10 substantially the same requirements in its state of
11 organization as is a "domestic company" under Article VIII
12 1/2 of the Illinois Insurance Code.

13 (c) In considering the merger, consolidation, or other
14 acquisition of control of a Health Maintenance Organization
15 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

16 (1) the Director shall give primary consideration to
17 the continuation of benefits to enrollees and the
18 financial conditions of the acquired Health Maintenance
19 Organization after the merger, consolidation, or other
20 acquisition of control takes effect;

21 (2) (i) the criteria specified in subsection (1) (b) of
22 Section 131.8 of the Illinois Insurance Code shall not
23 apply and (ii) the Director, in making his determination
24 with respect to the merger, consolidation, or other
25 acquisition of control, need not take into account the
26 effect on competition of the merger, consolidation, or

1 other acquisition of control;

2 (3) the Director shall have the power to require the
3 following information:

4 (A) certification by an independent actuary of the
5 adequacy of the reserves of the Health Maintenance
6 Organization sought to be acquired;

7 (B) pro forma financial statements reflecting the
8 combined balance sheets of the acquiring company and
9 the Health Maintenance Organization sought to be
10 acquired as of the end of the preceding year and as of
11 a date 90 days prior to the acquisition, as well as pro
12 forma financial statements reflecting projected
13 combined operation for a period of 2 years;

14 (C) a pro forma business plan detailing an
15 acquiring party's plans with respect to the operation
16 of the Health Maintenance Organization sought to be
17 acquired for a period of not less than 3 years; and

18 (D) such other information as the Director shall
19 require.

20 (d) The provisions of Article VIII 1/2 of the Illinois
21 Insurance Code and this Section 5-3 shall apply to the sale by
22 any health maintenance organization of greater than 10% of its
23 enrollee population (including without limitation the health
24 maintenance organization's right, title, and interest in and
25 to its health care certificates).

26 (e) In considering any management contract or service

1 agreement subject to Section 141.1 of the Illinois Insurance
2 Code, the Director (i) shall, in addition to the criteria
3 specified in Section 141.2 of the Illinois Insurance Code,
4 take into account the effect of the management contract or
5 service agreement on the continuation of benefits to enrollees
6 and the financial condition of the health maintenance
7 organization to be managed or serviced, and (ii) need not take
8 into account the effect of the management contract or service
9 agreement on competition.

10 (f) Except for small employer groups as defined in the
11 Small Employer Rating, Renewability and Portability Health
12 Insurance Act and except for medicare supplement policies as
13 defined in Section 363 of the Illinois Insurance Code, a
14 Health Maintenance Organization may by contract agree with a
15 group or other enrollment unit to effect refunds or charge
16 additional premiums under the following terms and conditions:

17 (i) the amount of, and other terms and conditions with
18 respect to, the refund or additional premium are set forth
19 in the group or enrollment unit contract agreed in advance
20 of the period for which a refund is to be paid or
21 additional premium is to be charged (which period shall
22 not be less than one year); and

23 (ii) the amount of the refund or additional premium
24 shall not exceed 20% of the Health Maintenance
25 Organization's profitable or unprofitable experience with
26 respect to the group or other enrollment unit for the

1 period (and, for purposes of a refund or additional
2 premium, the profitable or unprofitable experience shall
3 be calculated taking into account a pro rata share of the
4 Health Maintenance Organization's administrative and
5 marketing expenses, but shall not include any refund to be
6 made or additional premium to be paid pursuant to this
7 subsection (f)). The Health Maintenance Organization and
8 the group or enrollment unit may agree that the profitable
9 or unprofitable experience may be calculated taking into
10 account the refund period and the immediately preceding 2
11 plan years.

12 The Health Maintenance Organization shall include a
13 statement in the evidence of coverage issued to each enrollee
14 describing the possibility of a refund or additional premium,
15 and upon request of any group or enrollment unit, provide to
16 the group or enrollment unit a description of the method used
17 to calculate (1) the Health Maintenance Organization's
18 profitable experience with respect to the group or enrollment
19 unit and the resulting refund to the group or enrollment unit
20 or (2) the Health Maintenance Organization's unprofitable
21 experience with respect to the group or enrollment unit and
22 the resulting additional premium to be paid by the group or
23 enrollment unit.

24 In no event shall the Illinois Health Maintenance
25 Organization Guaranty Association be liable to pay any
26 contractual obligation of an insolvent organization to pay any

1 refund authorized under this Section.

2 (g) Rulemaking authority to implement Public Act 95-1045,
3 if any, is conditioned on the rules being adopted in
4 accordance with all provisions of the Illinois Administrative
5 Procedure Act and all rules and procedures of the Joint
6 Committee on Administrative Rules; any purported rule not so
7 adopted, for whatever reason, is unauthorized.

8 (Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19;
9 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff.
10 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625,
11 eff. 1-1-21; 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
12 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
13 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
14 eff. 10-8-21; revised 10-27-21.)

15 Section 30. The Limited Health Service Organization Act is
16 amended by changing Section 4003 as follows:

17 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

18 Sec. 4003. Illinois Insurance Code provisions. Limited
19 health service organizations shall be subject to the
20 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
21 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,
22 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 355.2, 355.3,
23 355b, 356q, 356v, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26,
24 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46,

1 356z.47, 356z.51, 364.3, ~~356z.43,~~ 368a, 401, 401.1, 402, 403,
2 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA,
3 VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the
4 Illinois Insurance Code. For purposes of the Illinois
5 Insurance Code, except for Sections 444 and 444.1 and Articles
6 XIII and XIII 1/2, limited health service organizations in the
7 following categories are deemed to be domestic companies:

8 (1) a corporation under the laws of this State; or

9 (2) a corporation organized under the laws of another
10 state, 30% or more of the enrollees of which are residents
11 of this State, except a corporation subject to
12 substantially the same requirements in its state of
13 organization as is a domestic company under Article VIII
14 1/2 of the Illinois Insurance Code.

15 (Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20;
16 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff.
17 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642,
18 eff. 1-1-22; revised 10-27-21.)

19 Section 35. The Voluntary Health Services Plans Act is
20 amended by changing Section 10 as follows:

21 (215 ILCS 165/10) (from Ch. 32, par. 604)

22 Sec. 10. Application of Insurance Code provisions. Health
23 services plan corporations and all persons interested therein
24 or dealing therewith shall be subject to the provisions of

1 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
2 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b,
3 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w,
4 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6,
5 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14,
6 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26,
7 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40,
8 356z.41, 356z.46, 356z.47, 356z.51, 356z.43, 364.01, 364.3,
9 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
10 and paragraphs (7) and (15) of Section 367 of the Illinois
11 Insurance Code.

12 Rulemaking authority to implement Public Act 95-1045, if
13 any, is conditioned on the rules being adopted in accordance
14 with all provisions of the Illinois Administrative Procedure
15 Act and all rules and procedures of the Joint Committee on
16 Administrative Rules; any purported rule not so adopted, for
17 whatever reason, is unauthorized.

18 (Source: P.A. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19;
19 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff.
20 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306,
21 eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21;
22 revised 10-27-21.)

23 Section 40. The Workers' Compensation Act is amended by
24 changing Section 19 as follows:

1 (820 ILCS 305/19) (from Ch. 48, par. 138.19)

2 Sec. 19. Any disputed questions of law or fact shall be
3 determined as herein provided.

4 (a) It shall be the duty of the Commission upon
5 notification that the parties have failed to reach an
6 agreement, to designate an Arbitrator.

7 1. Whenever any claimant misconceives his remedy and
8 files an application for adjustment of claim under this
9 Act and it is subsequently discovered, at any time before
10 final disposition of such cause, that the claim for
11 disability or death which was the basis for such
12 application should properly have been made under the
13 Workers' Occupational Diseases Act, then the provisions of
14 Section 19, paragraph (a-1) of the Workers' Occupational
15 Diseases Act having reference to such application shall
16 apply.

17 2. Whenever any claimant misconceives his remedy and
18 files an application for adjustment of claim under the
19 Workers' Occupational Diseases Act and it is subsequently
20 discovered, at any time before final disposition of such
21 cause that the claim for injury or death which was the
22 basis for such application should properly have been made
23 under this Act, then the application so filed under the
24 Workers' Occupational Diseases Act may be amended in form,
25 substance or both to assert claim for such disability or
26 death under this Act and it shall be deemed to have been so

1 filed as amended on the date of the original filing
2 thereof, and such compensation may be awarded as is
3 warranted by the whole evidence pursuant to this Act. When
4 such amendment is submitted, further or additional
5 evidence may be heard by the Arbitrator or Commission when
6 deemed necessary. Nothing in this Section contained shall
7 be construed to be or permit a waiver of any provisions of
8 this Act with reference to notice but notice if given
9 shall be deemed to be a notice under the provisions of this
10 Act if given within the time required herein.

11 (b) The Arbitrator shall make such inquiries and
12 investigations as he or they shall deem necessary and may
13 examine and inspect all books, papers, records, places, or
14 premises relating to the questions in dispute and hear such
15 proper evidence as the parties may submit.

16 The hearings before the Arbitrator shall be held in the
17 vicinity where the injury occurred after 10 days' notice of
18 the time and place of such hearing shall have been given to
19 each of the parties or their attorneys of record.

20 The Arbitrator may find that the disabling condition is
21 temporary and has not yet reached a permanent condition and
22 may order the payment of compensation up to the date of the
23 hearing, which award shall be reviewable and enforceable in
24 the same manner as other awards, and in no instance be a bar to
25 a further hearing and determination of a further amount of
26 temporary total compensation or of compensation for permanent

1 disability, but shall be conclusive as to all other questions
2 except the nature and extent of said disability.

3 The decision of the Arbitrator shall be filed with the
4 Commission which Commission shall immediately send to each
5 party or his attorney a copy of such decision, together with a
6 notification of the time when it was filed. As of the effective
7 date of this amendatory Act of the 94th General Assembly, all
8 decisions of the Arbitrator shall set forth in writing
9 findings of fact and conclusions of law, separately stated, if
10 requested by either party. Unless a petition for review is
11 filed by either party within 30 days after the receipt by such
12 party of the copy of the decision and notification of time when
13 filed, and unless such party petitioning for a review shall
14 within 35 days after the receipt by him of the copy of the
15 decision, file with the Commission either an agreed statement
16 of the facts appearing upon the hearing before the Arbitrator,
17 or if such party shall so elect a correct transcript of
18 evidence of the proceedings at such hearings, then the
19 decision shall become the decision of the Commission and in
20 the absence of fraud shall be conclusive. The Petition for
21 Review shall contain a statement of the petitioning party's
22 specific exceptions to the decision of the arbitrator. The
23 jurisdiction of the Commission to review the decision of the
24 arbitrator shall not be limited to the exceptions stated in
25 the Petition for Review. The Commission, or any member
26 thereof, may grant further time not exceeding 30 days, in

1 which to file such agreed statement or transcript of evidence.
2 Such agreed statement of facts or correct transcript of
3 evidence, as the case may be, shall be authenticated by the
4 signatures of the parties or their attorneys, and in the event
5 they do not agree as to the correctness of the transcript of
6 evidence it shall be authenticated by the signature of the
7 Arbitrator designated by the Commission.

8 Whether the employee is working or not, if the employee is
9 not receiving or has not received medical, surgical, or
10 hospital services or other services or compensation as
11 provided in paragraph (a) of Section 8, or compensation as
12 provided in paragraph (b) of Section 8, the employee may at any
13 time petition for an expedited hearing by an Arbitrator on the
14 issue of whether or not he or she is entitled to receive
15 payment of the services or compensation. Provided the employer
16 continues to pay compensation pursuant to paragraph (b) of
17 Section 8, the employer may at any time petition for an
18 expedited hearing on the issue of whether or not the employee
19 is entitled to receive medical, surgical, or hospital services
20 or other services or compensation as provided in paragraph (a)
21 of Section 8, or compensation as provided in paragraph (b) of
22 Section 8. When an employer has petitioned for an expedited
23 hearing, the employer shall continue to pay compensation as
24 provided in paragraph (b) of Section 8 unless the arbitrator
25 renders a decision that the employee is not entitled to the
26 benefits that are the subject of the expedited hearing or

1 unless the employee's treating physician has released the
2 employee to return to work at his or her regular job with the
3 employer or the employee actually returns to work at any other
4 job. If the arbitrator renders a decision that the employee is
5 not entitled to the benefits that are the subject of the
6 expedited hearing, a petition for review filed by the employee
7 shall receive the same priority as if the employee had filed a
8 petition for an expedited hearing by an Arbitrator. Neither
9 party shall be entitled to an expedited hearing when the
10 employee has returned to work and the sole issue in dispute
11 amounts to less than 12 weeks of unpaid compensation pursuant
12 to paragraph (b) of Section 8.

13 Expedited hearings shall have priority over all other
14 petitions and shall be heard by the Arbitrator and Commission
15 with all convenient speed. Any party requesting an expedited
16 hearing shall give notice of a request for an expedited
17 hearing under this paragraph. A copy of the Application for
18 Adjustment of Claim shall be attached to the notice. The
19 Commission shall adopt rules and procedures under which the
20 final decision of the Commission under this paragraph is filed
21 not later than 180 days from the date that the Petition for
22 Review is filed with the Commission.

23 Where 2 or more insurance carriers, private self-insureds,
24 or a group workers' compensation pool under Article V 3/4 of
25 the Illinois Insurance Code dispute coverage for the same
26 injury, any such insurance carrier, private self-insured, or

1 group workers' compensation pool may request an expedited
2 hearing pursuant to this paragraph to determine the issue of
3 coverage, provided coverage is the only issue in dispute and
4 all other issues are stipulated and agreed to and further
5 provided that all compensation benefits including medical
6 benefits pursuant to Section 8(a) continue to be paid to or on
7 behalf of petitioner. Any insurance carrier, private
8 self-insured, or group workers' compensation pool that is
9 determined to be liable for coverage for the injury in issue
10 shall reimburse any insurance carrier, private self-insured,
11 or group workers' compensation pool that has paid benefits to
12 or on behalf of petitioner for the injury.

13 (b-1) If the employee is not receiving medical, surgical
14 or hospital services as provided in paragraph (a) of Section 8
15 or compensation as provided in paragraph (b) of Section 8, the
16 employee, in accordance with Commission Rules, may file a
17 petition for an emergency hearing by an Arbitrator on the
18 issue of whether or not he is entitled to receive payment of
19 such compensation or services as provided therein. Such
20 petition shall have priority over all other petitions and
21 shall be heard by the Arbitrator and Commission with all
22 convenient speed.

23 Such petition shall contain the following information and
24 shall be served on the employer at least 15 days before it is
25 filed:

26 (i) the date and approximate time of accident;

- 1 (ii) the approximate location of the accident;
- 2 (iii) a description of the accident;
- 3 (iv) the nature of the injury incurred by the
4 employee;
- 5 (v) the identity of the person, if known, to whom the
6 accident was reported and the date on which it was
7 reported;
- 8 (vi) the name and title of the person, if known,
9 representing the employer with whom the employee conferred
10 in any effort to obtain compensation pursuant to paragraph
11 (b) of Section 8 of this Act or medical, surgical or
12 hospital services pursuant to paragraph (a) of Section 8
13 of this Act and the date of such conference;
- 14 (vii) a statement that the employer has refused to pay
15 compensation pursuant to paragraph (b) of Section 8 of
16 this Act or for medical, surgical or hospital services
17 pursuant to paragraph (a) of Section 8 of this Act;
- 18 (viii) the name and address, if known, of each witness
19 to the accident and of each other person upon whom the
20 employee will rely to support his allegations;
- 21 (ix) the dates of treatment related to the accident by
22 medical practitioners, and the names and addresses of such
23 practitioners, including the dates of treatment related to
24 the accident at any hospitals and the names and addresses
25 of such hospitals, and a signed authorization permitting
26 the employer to examine all medical records of all

1 practitioners and hospitals named pursuant to this
2 paragraph;

3 (x) a copy of a signed report by a medical
4 practitioner, relating to the employee's current inability
5 to return to work because of the injuries incurred as a
6 result of the accident or such other documents or
7 affidavits which show that the employee is entitled to
8 receive compensation pursuant to paragraph (b) of Section
9 8 of this Act or medical, surgical or hospital services
10 pursuant to paragraph (a) of Section 8 of this Act. Such
11 reports, documents or affidavits shall state, if possible,
12 the history of the accident given by the employee, and
13 describe the injury and medical diagnosis, the medical
14 services for such injury which the employee has received
15 and is receiving, the physical activities which the
16 employee cannot currently perform as a result of any
17 impairment or disability due to such injury, and the
18 prognosis for recovery;

19 (xi) complete copies of any reports, records,
20 documents and affidavits in the possession of the employee
21 on which the employee will rely to support his
22 allegations, provided that the employer shall pay the
23 reasonable cost of reproduction thereof;

24 (xii) a list of any reports, records, documents and
25 affidavits which the employee has demanded by subpoena and
26 on which he intends to rely to support his allegations;

1 (xiii) a certification signed by the employee or his
2 representative that the employer has received the petition
3 with the required information 15 days before filing.

4 Fifteen days after receipt by the employer of the petition
5 with the required information the employee may file said
6 petition and required information and shall serve notice of
7 the filing upon the employer. The employer may file a motion
8 addressed to the sufficiency of the petition. If an objection
9 has been filed to the sufficiency of the petition, the
10 arbitrator shall rule on the objection within 2 working days.
11 If such an objection is filed, the time for filing the final
12 decision of the Commission as provided in this paragraph shall
13 be tolled until the arbitrator has determined that the
14 petition is sufficient.

15 The employer shall, within 15 days after receipt of the
16 notice that such petition is filed, file with the Commission
17 and serve on the employee or his representative a written
18 response to each claim set forth in the petition, including
19 the legal and factual basis for each disputed allegation and
20 the following information: (i) complete copies of any reports,
21 records, documents and affidavits in the possession of the
22 employer on which the employer intends to rely in support of
23 his response, (ii) a list of any reports, records, documents
24 and affidavits which the employer has demanded by subpoena and
25 on which the employer intends to rely in support of his
26 response, (iii) the name and address of each witness on whom

1 the employer will rely to support his response, and (iv) the
2 names and addresses of any medical practitioners selected by
3 the employer pursuant to Section 12 of this Act and the time
4 and place of any examination scheduled to be made pursuant to
5 such Section.

6 Any employer who does not timely file and serve a written
7 response without good cause may not introduce any evidence to
8 dispute any claim of the employee but may cross examine the
9 employee or any witness brought by the employee and otherwise
10 be heard.

11 No document or other evidence not previously identified by
12 either party with the petition or written response, or by any
13 other means before the hearing, may be introduced into
14 evidence without good cause. If, at the hearing, material
15 information is discovered which was not previously disclosed,
16 the Arbitrator may extend the time for closing proof on the
17 motion of a party for a reasonable period of time which may be
18 more than 30 days. No evidence may be introduced pursuant to
19 this paragraph as to permanent disability. No award may be
20 entered for permanent disability pursuant to this paragraph.
21 Either party may introduce into evidence the testimony taken
22 by deposition of any medical practitioner.

23 The Commission shall adopt rules, regulations and
24 procedures whereby the final decision of the Commission is
25 filed not later than 90 days from the date the petition for
26 review is filed but in no event later than 180 days from the

1 date the petition for an emergency hearing is filed with the
2 Illinois Workers' Compensation Commission.

3 All service required pursuant to this paragraph (b-1) must
4 be by personal service or by certified mail and with evidence
5 of receipt. In addition for the purposes of this paragraph,
6 all service on the employer must be at the premises where the
7 accident occurred if the premises are owned or operated by the
8 employer. Otherwise service must be at the employee's
9 principal place of employment by the employer. If service on
10 the employer is not possible at either of the above, then
11 service shall be at the employer's principal place of
12 business. After initial service in each case, service shall be
13 made on the employer's attorney or designated representative.

14 (c)(1) At a reasonable time in advance of and in
15 connection with the hearing under Section 19(e) or 19(h), the
16 Commission may on its own motion order an impartial physical
17 or mental examination of a petitioner whose mental or physical
18 condition is in issue, when in the Commission's discretion it
19 appears that such an examination will materially aid in the
20 just determination of the case. The examination shall be made
21 by a member or members of a panel of physicians chosen for
22 their special qualifications by the Illinois State Medical
23 Society. The Commission shall establish procedures by which a
24 physician shall be selected from such list.

25 (2) Should the Commission at any time during the hearing
26 find that compelling considerations make it advisable to have

1 an examination and report at that time, the commission may in
2 its discretion so order.

3 (3) A copy of the report of examination shall be given to
4 the Commission and to the attorneys for the parties.

5 (4) Either party or the Commission may call the examining
6 physician or physicians to testify. Any physician so called
7 shall be subject to cross-examination.

8 (5) The examination shall be made, and the physician or
9 physicians, if called, shall testify, without cost to the
10 parties. The Commission shall determine the compensation and
11 the pay of the physician or physicians. The compensation for
12 this service shall not exceed the usual and customary amount
13 for such service.

14 (6) The fees and payment thereof of all attorneys and
15 physicians for services authorized by the Commission under
16 this Act shall, upon request of either the employer or the
17 employee or the beneficiary affected, be subject to the review
18 and decision of the Commission.

19 (d) If any employee shall persist in insanitary or
20 injurious practices which tend to either imperil or retard his
21 recovery or shall refuse to submit to such medical, surgical,
22 or hospital treatment as is reasonably essential to promote
23 his recovery, the Commission may, in its discretion, reduce or
24 suspend the compensation of any such injured employee.
25 However, when an employer and employee so agree in writing,
26 the foregoing provision shall not be construed to authorize

1 the reduction or suspension of compensation of an employee who
2 is relying in good faith, on treatment by prayer or spiritual
3 means alone, in accordance with the tenets and practice of a
4 recognized church or religious denomination, by a duly
5 accredited practitioner thereof.

6 (e) This paragraph shall apply to all hearings before the
7 Commission. Such hearings may be held in its office or
8 elsewhere as the Commission may deem advisable. The taking of
9 testimony on such hearings may be had before any member of the
10 Commission. If a petition for review and agreed statement of
11 facts or transcript of evidence is filed, as provided herein,
12 the Commission shall promptly review the decision of the
13 Arbitrator and all questions of law or fact which appear from
14 the statement of facts or transcript of evidence.

15 In all cases in which the hearing before the arbitrator is
16 held after December 18, 1989, no additional evidence shall be
17 introduced by the parties before the Commission on review of
18 the decision of the Arbitrator. In reviewing decisions of an
19 arbitrator the Commission shall award such temporary
20 compensation, permanent compensation and other payments as are
21 due under this Act. The Commission shall file in its office its
22 decision thereon, and shall immediately send to each party or
23 his attorney a copy of such decision and a notification of the
24 time when it was filed. Decisions shall be filed within 60 days
25 after the Statement of Exceptions and Supporting Brief and
26 Response thereto are required to be filed or oral argument

1 whichever is later.

2 In the event either party requests oral argument, such
3 argument shall be had before a panel of 3 members of the
4 Commission (or before all available members pursuant to the
5 determination of 7 members of the Commission that such
6 argument be held before all available members of the
7 Commission) pursuant to the rules and regulations of the
8 Commission. A panel of 3 members, which shall be comprised of
9 not more than one representative citizen of the employing
10 class and not more than one representative from a labor
11 organization recognized under the National Labor Relations Act
12 or an attorney who has represented labor organizations or has
13 represented employees in workers' compensation cases, shall
14 hear the argument; provided that if all the issues in dispute
15 are solely the nature and extent of the permanent partial
16 disability, if any, a majority of the panel may deny the
17 request for such argument and such argument shall not be held;
18 and provided further that 7 members of the Commission may
19 determine that the argument be held before all available
20 members of the Commission. A decision of the Commission shall
21 be approved by a majority of Commissioners present at such
22 hearing if any; provided, if no such hearing is held, a
23 decision of the Commission shall be approved by a majority of a
24 panel of 3 members of the Commission as described in this
25 Section. The Commission shall give 10 days' notice to the
26 parties or their attorneys of the time and place of such taking

1 of testimony and of such argument.

2 In any case the Commission in its decision may find
3 specially upon any question or questions of law or fact which
4 shall be submitted in writing by either party whether ultimate
5 or otherwise; provided that on issues other than nature and
6 extent of the disability, if any, the Commission in its
7 decision shall find specially upon any question or questions
8 of law or fact, whether ultimate or otherwise, which are
9 submitted in writing by either party; provided further that
10 not more than 5 such questions may be submitted by either
11 party. Any party may, within 20 days after receipt of notice of
12 the Commission's decision, or within such further time, not
13 exceeding 30 days, as the Commission may grant, file with the
14 Commission either an agreed statement of the facts appearing
15 upon the hearing, or, if such party shall so elect, a correct
16 transcript of evidence of the additional proceedings presented
17 before the Commission, in which report the party may embody a
18 correct statement of such other proceedings in the case as
19 such party may desire to have reviewed, such statement of
20 facts or transcript of evidence to be authenticated by the
21 signature of the parties or their attorneys, and in the event
22 that they do not agree, then the authentication of such
23 transcript of evidence shall be by the signature of any member
24 of the Commission.

25 If a reporter does not for any reason furnish a transcript
26 of the proceedings before the Arbitrator in any case for use on

1 a hearing for review before the Commission, within the
2 limitations of time as fixed in this Section, the Commission
3 may, in its discretion, order a trial de novo before the
4 Commission in such case upon application of either party. The
5 applications for adjustment of claim and other documents in
6 the nature of pleadings filed by either party, together with
7 the decisions of the Arbitrator and of the Commission and the
8 statement of facts or transcript of evidence hereinbefore
9 provided for in paragraphs (b) and (c) shall be the record of
10 the proceedings of the Commission, and shall be subject to
11 review as hereinafter provided.

12 At the request of either party or on its own motion, the
13 Commission shall set forth in writing the reasons for the
14 decision, including findings of fact and conclusions of law
15 separately stated. The Commission shall by rule adopt a format
16 for written decisions for the Commission and arbitrators. The
17 written decisions shall be concise and shall succinctly state
18 the facts and reasons for the decision. The Commission may
19 adopt in whole or in part, the decision of the arbitrator as
20 the decision of the Commission. When the Commission does so
21 adopt the decision of the arbitrator, it shall do so by order.
22 Whenever the Commission adopts part of the arbitrator's
23 decision, but not all, it shall include in the order the
24 reasons for not adopting all of the arbitrator's decision.
25 When a majority of a panel, after deliberation, has arrived at
26 its decision, the decision shall be filed as provided in this

1 Section without unnecessary delay, and without regard to the
2 fact that a member of the panel has expressed an intention to
3 dissent. Any member of the panel may file a dissent. Any
4 dissent shall be filed no later than 10 days after the decision
5 of the majority has been filed.

6 Decisions rendered by the Commission and dissents, if any,
7 shall be published together by the Commission. The conclusions
8 of law set out in such decisions shall be regarded as
9 precedents by arbitrators for the purpose of achieving a more
10 uniform administration of this Act.

11 (f) The decision of the Commission acting within its
12 powers, according to the provisions of paragraph (e) of this
13 Section shall, in the absence of fraud, be conclusive unless
14 reviewed as in this paragraph hereinafter provided. However,
15 the Arbitrator or the Commission may on his or its own motion,
16 or on the motion of either party, correct any clerical error or
17 errors in computation within 15 days after the date of receipt
18 of any award by such Arbitrator or any decision on review of
19 the Commission and shall have the power to recall the original
20 award on arbitration or decision on review, and issue in lieu
21 thereof such corrected award or decision. Where such
22 correction is made the time for review herein specified shall
23 begin to run from the date of the receipt of the corrected
24 award or decision.

25 (1) Except in cases of claims against the State of
26 Illinois other than those claims under Section 18.1, in

1 which case the decision of the Commission shall not be
2 subject to judicial review, the Circuit Court of the
3 county where any of the parties defendant may be found, or
4 if none of the parties defendant can be found in this State
5 then the Circuit Court of the county where the accident
6 occurred, shall by summons to the Commission have power to
7 review all questions of law and fact presented by such
8 record.

9 A proceeding for review shall be commenced within 20
10 days of the receipt of notice of the decision of the
11 Commission. The summons shall be issued by the clerk of
12 such court upon written request returnable on a designated
13 return day, not less than 10 or more than 60 days from the
14 date of issuance thereof, and the written request shall
15 contain the last known address of other parties in
16 interest and their attorneys of record who are to be
17 served by summons. Service upon any member of the
18 Commission or the Secretary or the Assistant Secretary
19 thereof shall be service upon the Commission, and service
20 upon other parties in interest and their attorneys of
21 record shall be by summons, and such service shall be made
22 upon the Commission and other parties in interest by
23 mailing notices of the commencement of the proceedings and
24 the return day of the summons to the office of the
25 Commission and to the last known place of residence of
26 other parties in interest or their attorney or attorneys

1 of record. The clerk of the court issuing the summons
2 shall on the day of issue mail notice of the commencement
3 of the proceedings which shall be done by mailing a copy of
4 the summons to the office of the Commission, and a copy of
5 the summons to the other parties in interest or their
6 attorney or attorneys of record and the clerk of the court
7 shall make certificate that he has so sent said notices in
8 pursuance of this Section, which shall be evidence of
9 service on the Commission and other parties in interest.

10 The Commission shall not be required to certify the
11 record of their proceedings to the Circuit Court, unless
12 the party commencing the proceedings for review in the
13 Circuit Court as above provided, shall file with the
14 Commission notice of intent to file for review in Circuit
15 Court. It shall be the duty of the Commission upon such
16 filing of notice of intent to file for review in the
17 Circuit Court to prepare a true and correct copy of such
18 testimony and a true and correct copy of all other matters
19 contained in such record and certified to by the Secretary
20 or Assistant Secretary thereof. The changes made to this
21 subdivision (f)(1) by this amendatory Act of the 98th
22 General Assembly apply to any Commission decision entered
23 after the effective date of this amendatory Act of the
24 98th General Assembly.

25 No request for a summons may be filed and no summons
26 shall issue unless the party seeking to review the

1 decision of the Commission shall exhibit to the clerk of
2 the Circuit Court proof of filing with the Commission of
3 the notice of the intent to file for review in the Circuit
4 Court or an affidavit of the attorney setting forth that
5 notice of intent to file for review in the Circuit Court
6 has been given in writing to the Secretary or Assistant
7 Secretary of the Commission.

8 (2) No such summons shall issue unless the one against
9 whom the Commission shall have rendered an award for the
10 payment of money shall upon the filing of his written
11 request for such summons file with the clerk of the court a
12 bond conditioned that if he shall not successfully
13 prosecute the review, he will pay the award and the costs
14 of the proceedings in the courts. The amount of the bond
15 shall be fixed by any member of the Commission and the
16 surety or sureties of the bond shall be approved by the
17 clerk of the court. The acceptance of the bond by the clerk
18 of the court shall constitute evidence of his approval of
19 the bond.

20 The following ~~Every county, city, town, township,~~
21 ~~incorporated village, school district, body politic or~~
22 ~~municipal corporation against whom the Commission shall~~
23 ~~have rendered an award for the payment of money~~ shall not
24 be required to file a bond to secure the payment of the
25 award and the costs of the proceedings in the court to
26 authorize the court to issue such summons:—

1 (1) the State Treasurer, for a fund administered
2 by the State Treasurer ex officio against whom the
3 Commission shall have rendered an award for the
4 payment of money; and

5 (2) a county, city, town, township, incorporated
6 village, school district, body politic, or municipal
7 corporation against whom the Commission shall have
8 rendered an award for the payment of money.

9 The court may confirm or set aside the decision of the
10 Commission. If the decision is set aside and the facts
11 found in the proceedings before the Commission are
12 sufficient, the court may enter such decision as is
13 justified by law, or may remand the cause to the
14 Commission for further proceedings and may state the
15 questions requiring further hearing, and give such other
16 instructions as may be proper. Appeals shall be taken to
17 the Appellate Court in accordance with Supreme Court Rules
18 22(g) and 303. Appeals shall be taken from the Appellate
19 Court to the Supreme Court in accordance with Supreme
20 Court Rule 315.

21 It shall be the duty of the clerk of any court
22 rendering a decision affecting or affirming an award of
23 the Commission to promptly furnish the Commission with a
24 copy of such decision, without charge.

25 The decision of a majority of the members of the panel
26 of the Commission, shall be considered the decision of the

1 Commission.

2 (g) Except in the case of a claim against the State of
3 Illinois, either party may present a certified copy of the
4 award of the Arbitrator, or a certified copy of the decision of
5 the Commission when the same has become final, when no
6 proceedings for review are pending, providing for the payment
7 of compensation according to this Act, to the Circuit Court of
8 the county in which such accident occurred or either of the
9 parties are residents, whereupon the court shall enter a
10 judgment in accordance therewith. In a case where the employer
11 refuses to pay compensation according to such final award or
12 such final decision upon which such judgment is entered the
13 court shall in entering judgment thereon, tax as costs against
14 him the reasonable costs and attorney fees in the arbitration
15 proceedings and in the court entering the judgment for the
16 person in whose favor the judgment is entered, which judgment
17 and costs taxed as therein provided shall, until and unless
18 set aside, have the same effect as though duly entered in an
19 action duly tried and determined by the court, and shall with
20 like effect, be entered and docketed. The Circuit Court shall
21 have power at any time upon application to make any such
22 judgment conform to any modification required by any
23 subsequent decision of the Supreme Court upon appeal, or as
24 the result of any subsequent proceedings for review, as
25 provided in this Act.

26 Judgment shall not be entered until 15 days' notice of the

1 time and place of the application for the entry of judgment
2 shall be served upon the employer by filing such notice with
3 the Commission, which Commission shall, in case it has on file
4 the address of the employer or the name and address of its
5 agent upon whom notices may be served, immediately send a copy
6 of the notice to the employer or such designated agent.

7 (h) An agreement or award under this Act providing for
8 compensation in installments, may at any time within 18 months
9 after such agreement or award be reviewed by the Commission at
10 the request of either the employer or the employee, on the
11 ground that the disability of the employee has subsequently
12 recurred, increased, diminished or ended.

13 However, as to accidents occurring subsequent to July 1,
14 1955, which are covered by any agreement or award under this
15 Act providing for compensation in installments made as a
16 result of such accident, such agreement or award may at any
17 time within 30 months, or 60 months in the case of an award
18 under Section 8(d)1, after such agreement or award be reviewed
19 by the Commission at the request of either the employer or the
20 employee on the ground that the disability of the employee has
21 subsequently recurred, increased, diminished or ended.

22 On such review, compensation payments may be
23 re-established, increased, diminished or ended. The Commission
24 shall give 15 days' notice to the parties of the hearing for
25 review. Any employee, upon any petition for such review being
26 filed by the employer, shall be entitled to one day's notice

1 for each 100 miles necessary to be traveled by him in attending
2 the hearing of the Commission upon the petition, and 3 days in
3 addition thereto. Such employee shall, at the discretion of
4 the Commission, also be entitled to 5 cents per mile
5 necessarily traveled by him within the State of Illinois in
6 attending such hearing, not to exceed a distance of 300 miles,
7 to be taxed by the Commission as costs and deposited with the
8 petition of the employer.

9 When compensation which is payable in accordance with an
10 award or settlement contract approved by the Commission, is
11 ordered paid in a lump sum by the Commission, no review shall
12 be had as in this paragraph mentioned.

13 (i) Each party, upon taking any proceedings or steps
14 whatsoever before any Arbitrator, Commission or court, shall
15 file with the Commission his address, or the name and address
16 of any agent upon whom all notices to be given to such party
17 shall be served, either personally or by registered mail,
18 addressed to such party or agent at the last address so filed
19 with the Commission. In the event such party has not filed his
20 address, or the name and address of an agent as above provided,
21 service of any notice may be had by filing such notice with the
22 Commission.

23 (j) Whenever in any proceeding testimony has been taken or
24 a final decision has been rendered and after the taking of such
25 testimony or after such decision has become final, the injured
26 employee dies, then in any subsequent proceedings brought by

1 the personal representative or beneficiaries of the deceased
2 employee, such testimony in the former proceeding may be
3 introduced with the same force and effect as though the
4 witness having so testified were present in person in such
5 subsequent proceedings and such final decision, if any, shall
6 be taken as final adjudication of any of the issues which are
7 the same in both proceedings.

8 (k) In case where there has been any unreasonable or
9 vexatious delay of payment or intentional underpayment of
10 compensation, or proceedings have been instituted or carried
11 on by the one liable to pay the compensation, which do not
12 present a real controversy, but are merely frivolous or for
13 delay, then the Commission may award compensation additional
14 to that otherwise payable under this Act equal to 50% of the
15 amount payable at the time of such award. Failure to pay
16 compensation in accordance with the provisions of Section 8,
17 paragraph (b) of this Act, shall be considered unreasonable
18 delay.

19 When determining whether this subsection (k) shall apply,
20 the Commission shall consider whether an Arbitrator has
21 determined that the claim is not compensable or whether the
22 employer has made payments under Section 8(j).

23 (l) If the employee has made written demand for payment of
24 benefits under Section 8(a) or Section 8(b), the employer
25 shall have 14 days after receipt of the demand to set forth in
26 writing the reason for the delay. In the case of demand for

1 payment of medical benefits under Section 8(a), the time for
2 the employer to respond shall not commence until the
3 expiration of the allotted 30 days specified under Section
4 8.2(d). In case the employer or his or her insurance carrier
5 shall without good and just cause fail, neglect, refuse, or
6 unreasonably delay the payment of benefits under Section 8(a)
7 or Section 8(b), the Arbitrator or the Commission shall allow
8 to the employee additional compensation in the sum of \$30 per
9 day for each day that the benefits under Section 8(a) or
10 Section 8(b) have been so withheld or refused, not to exceed
11 \$10,000. A delay in payment of 14 days or more shall create a
12 rebuttable presumption of unreasonable delay.

13 (m) If the commission finds that an accidental injury was
14 directly and proximately caused by the employer's wilful
15 violation of a health and safety standard under the Health and
16 Safety Act or the Occupational Safety and Health Act in force
17 at the time of the accident, the arbitrator or the Commission
18 shall allow to the injured employee or his dependents, as the
19 case may be, additional compensation equal to 25% of the
20 amount which otherwise would be payable under the provisions
21 of this Act exclusive of this paragraph. The additional
22 compensation herein provided shall be allowed by an
23 appropriate increase in the applicable weekly compensation
24 rate.

25 (n) After June 30, 1984, decisions of the Illinois
26 Workers' Compensation Commission reviewing an award of an

1 arbitrator of the Commission shall draw interest at a rate
2 equal to the yield on indebtedness issued by the United States
3 Government with a 26-week maturity next previously auctioned
4 on the day on which the decision is filed. Said rate of
5 interest shall be set forth in the Arbitrator's Decision.
6 Interest shall be drawn from the date of the arbitrator's
7 award on all accrued compensation due the employee through the
8 day prior to the date of payments. However, when an employee
9 appeals an award of an Arbitrator or the Commission, and the
10 appeal results in no change or a decrease in the award,
11 interest shall not further accrue from the date of such
12 appeal.

13 The employer or his insurance carrier may tender the
14 payments due under the award to stop the further accrual of
15 interest on such award notwithstanding the prosecution by
16 either party of review, certiorari, appeal to the Supreme
17 Court or other steps to reverse, vacate or modify the award.

18 (o) By the 15th day of each month each insurer providing
19 coverage for losses under this Act shall notify each insured
20 employer of any compensable claim incurred during the
21 preceding month and the amounts paid or reserved on the claim
22 including a summary of the claim and a brief statement of the
23 reasons for compensability. A cumulative report of all claims
24 incurred during a calendar year or continued from the previous
25 year shall be furnished to the insured employer by the insurer
26 within 30 days after the end of that calendar year.

1 The insured employer may challenge, in proceeding before
2 the Commission, payments made by the insurer without
3 arbitration and payments made after a case is determined to be
4 noncompensable. If the Commission finds that the case was not
5 compensable, the insurer shall purge its records as to that
6 employer of any loss or expense associated with the claim,
7 reimburse the employer for attorneys' fees arising from the
8 challenge and for any payment required of the employer to the
9 Rate Adjustment Fund or the Second Injury Fund, and may not
10 reflect the loss or expense for rate making purposes. The
11 employee shall not be required to refund the challenged
12 payment. The decision of the Commission may be reviewed in the
13 same manner as in arbitrated cases. No challenge may be
14 initiated under this paragraph more than 3 years after the
15 payment is made. An employer may waive the right of challenge
16 under this paragraph on a case by case basis.

17 (p) After filing an application for adjustment of claim
18 but prior to the hearing on arbitration the parties may
19 voluntarily agree to submit such application for adjustment of
20 claim for decision by an arbitrator under this subsection (p)
21 where such application for adjustment of claim raises only a
22 dispute over temporary total disability, permanent partial
23 disability or medical expenses. Such agreement shall be in
24 writing in such form as provided by the Commission.
25 Applications for adjustment of claim submitted for decision by
26 an arbitrator under this subsection (p) shall proceed

1 according to rule as established by the Commission. The
2 Commission shall promulgate rules including, but not limited
3 to, rules to ensure that the parties are adequately informed
4 of their rights under this subsection (p) and of the voluntary
5 nature of proceedings under this subsection (p). The findings
6 of fact made by an arbitrator acting within his or her powers
7 under this subsection (p) in the absence of fraud shall be
8 conclusive. However, the arbitrator may on his own motion, or
9 the motion of either party, correct any clerical errors or
10 errors in computation within 15 days after the date of receipt
11 of such award of the arbitrator and shall have the power to
12 recall the original award on arbitration, and issue in lieu
13 thereof such corrected award. The decision of the arbitrator
14 under this subsection (p) shall be considered the decision of
15 the Commission and proceedings for review of questions of law
16 arising from the decision may be commenced by either party
17 pursuant to subsection (f) of Section 19. The Advisory Board
18 established under Section 13.1 shall compile a list of
19 certified Commission arbitrators, each of whom shall be
20 approved by at least 7 members of the Advisory Board. The
21 chairman shall select 5 persons from such list to serve as
22 arbitrators under this subsection (p). By agreement, the
23 parties shall select one arbitrator from among the 5 persons
24 selected by the chairman except that if the parties do not
25 agree on an arbitrator from among the 5 persons, the parties
26 may, by agreement, select an arbitrator of the American

1 Arbitration Association, whose fee shall be paid by the State
2 in accordance with rules promulgated by the Commission.
3 Arbitration under this subsection (p) shall be voluntary.
4 (Source: P.A. 101-384, eff. 1-1-20.)

5 Section 45. The Workers' Occupational Diseases Act is
6 amended by changing Section 19 as follows:

7 (820 ILCS 310/19) (from Ch. 48, par. 172.54)

8 Sec. 19. Any disputed questions of law or fact shall be
9 determined as herein provided.

10 (a) It shall be the duty of the Commission upon
11 notification that the parties have failed to reach an
12 agreement to designate an Arbitrator.

13 (1) The application for adjustment of claim filed with
14 the Commission shall state:

15 A. The approximate date of the last day of the last
16 exposure and the approximate date of the disablement.

17 B. The general nature and character of the illness
18 or disease claimed.

19 C. The name and address of the employer by whom
20 employed on the last day of the last exposure and if
21 employed by any other employer after such last
22 exposure and before disablement the name and address
23 of such other employer or employers.

24 D. In case of death, the date and place of death.

1 (2) Amendments to applications for adjustment of claim
2 which relate to the same disablement or disablement
3 resulting in death originally claimed upon may be allowed
4 by the Commissioner or an Arbitrator thereof, in their
5 discretion, and in the exercise of such discretion, they
6 may in proper cases order a trial de novo; such amendment
7 shall relate back to the date of the filing of the original
8 application so amended.

9 (3) Whenever any claimant misconceives his remedy and
10 files an application for adjustment of claim under this
11 Act and it is subsequently discovered, at any time before
12 final disposition of such cause, that the claim for
13 disability or death which was the basis for such
14 application should properly have been made under the
15 Workers' Compensation Act, then the provisions of Section
16 19 paragraph (a-1) of the Workers' Compensation Act having
17 reference to such application shall apply.

18 Whenever any claimant misconceives his remedy and
19 files an application for adjustment of claim under the
20 Workers' Compensation Act and it is subsequently
21 discovered, at any time before final disposition of such
22 cause that the claim for injury or death which was the
23 basis for such application should properly have been made
24 under this Act, then the application so filed under the
25 Workers' Compensation Act may be amended in form,
26 substance or both to assert claim for such disability or

1 death under this Act and it shall be deemed to have been so
2 filed as amended on the date of the original filing
3 thereof, and such compensation may be awarded as is
4 warranted by the whole evidence pursuant to the provisions
5 of this Act. When such amendment is submitted, further or
6 additional evidence may be heard by the Arbitrator or
7 Commission when deemed necessary; provided, that nothing
8 in this Section contained shall be construed to be or
9 permit a waiver of any provisions of this Act with
10 reference to notice, but notice if given shall be deemed
11 to be a notice under the provisions of this Act if given
12 within the time required herein.

13 (b) The Arbitrator shall make such inquiries and
14 investigations as he shall deem necessary and may examine and
15 inspect all books, papers, records, places, or premises
16 relating to the questions in dispute and hear such proper
17 evidence as the parties may submit.

18 The hearings before the Arbitrator shall be held in the
19 vicinity where the last exposure occurred, after 10 days'
20 notice of the time and place of such hearing shall have been
21 given to each of the parties or their attorneys of record.

22 The Arbitrator may find that the disabling condition is
23 temporary and has not yet reached a permanent condition and
24 may order the payment of compensation up to the date of the
25 hearing, which award shall be reviewable and enforceable in
26 the same manner as other awards, and in no instance be a bar to

1 a further hearing and determination of a further amount of
2 temporary total compensation or of compensation for permanent
3 disability, but shall be conclusive as to all other questions
4 except the nature and extent of such disability.

5 The decision of the Arbitrator shall be filed with the
6 Commission which Commission shall immediately send to each
7 party or his attorney a copy of such decision, together with a
8 notification of the time when it was filed. As of the effective
9 date of this amendatory Act of the 94th General Assembly, all
10 decisions of the Arbitrator shall set forth in writing
11 findings of fact and conclusions of law, separately stated, if
12 requested by either party. Unless a petition for review is
13 filed by either party within 30 days after the receipt by such
14 party of the copy of the decision and notification of time when
15 filed, and unless such party petitioning for a review shall
16 within 35 days after the receipt by him of the copy of the
17 decision, file with the Commission either an agreed statement
18 of the facts appearing upon the hearing before the Arbitrator,
19 or if such party shall so elect a correct transcript of
20 evidence of the proceedings at such hearings, then the
21 decision shall become the decision of the Commission and in
22 the absence of fraud shall be conclusive. The Petition for
23 Review shall contain a statement of the petitioning party's
24 specific exceptions to the decision of the arbitrator. The
25 jurisdiction of the Commission to review the decision of the
26 arbitrator shall not be limited to the exceptions stated in

1 the Petition for Review. The Commission, or any member
2 thereof, may grant further time not exceeding 30 days, in
3 which to file such agreed statement or transcript of evidence.
4 Such agreed statement of facts or correct transcript of
5 evidence, as the case may be, shall be authenticated by the
6 signatures of the parties or their attorneys, and in the event
7 they do not agree as to the correctness of the transcript of
8 evidence it shall be authenticated by the signature of the
9 Arbitrator designated by the Commission.

10 Whether the employee is working or not, if the employee is
11 not receiving or has not received medical, surgical, or
12 hospital services or other services or compensation as
13 provided in paragraph (a) of Section 8 of the Workers'
14 Compensation Act, or compensation as provided in paragraph (b)
15 of Section 8 of the Workers' Compensation Act, the employee
16 may at any time petition for an expedited hearing by an
17 Arbitrator on the issue of whether or not he or she is entitled
18 to receive payment of the services or compensation. Provided
19 the employer continues to pay compensation pursuant to
20 paragraph (b) of Section 8 of the Workers' Compensation Act,
21 the employer may at any time petition for an expedited hearing
22 on the issue of whether or not the employee is entitled to
23 receive medical, surgical, or hospital services or other
24 services or compensation as provided in paragraph (a) of
25 Section 8 of the Workers' Compensation Act, or compensation as
26 provided in paragraph (b) of Section 8 of the Workers'

1 Compensation Act. When an employer has petitioned for an
2 expedited hearing, the employer shall continue to pay
3 compensation as provided in paragraph (b) of Section 8 of the
4 Workers' Compensation Act unless the arbitrator renders a
5 decision that the employee is not entitled to the benefits
6 that are the subject of the expedited hearing or unless the
7 employee's treating physician has released the employee to
8 return to work at his or her regular job with the employer or
9 the employee actually returns to work at any other job. If the
10 arbitrator renders a decision that the employee is not
11 entitled to the benefits that are the subject of the expedited
12 hearing, a petition for review filed by the employee shall
13 receive the same priority as if the employee had filed a
14 petition for an expedited hearing by an arbitrator. Neither
15 party shall be entitled to an expedited hearing when the
16 employee has returned to work and the sole issue in dispute
17 amounts to less than 12 weeks of unpaid compensation pursuant
18 to paragraph (b) of Section 8 of the Workers' Compensation
19 Act.

20 Expedited hearings shall have priority over all other
21 petitions and shall be heard by the Arbitrator and Commission
22 with all convenient speed. Any party requesting an expedited
23 hearing shall give notice of a request for an expedited
24 hearing under this paragraph. A copy of the Application for
25 Adjustment of Claim shall be attached to the notice. The
26 Commission shall adopt rules and procedures under which the

1 final decision of the Commission under this paragraph is filed
2 not later than 180 days from the date that the Petition for
3 Review is filed with the Commission.

4 Where 2 or more insurance carriers, private self-insureds,
5 or a group workers' compensation pool under Article V 3/4 of
6 the Illinois Insurance Code dispute coverage for the same
7 disease, any such insurance carrier, private self-insured, or
8 group workers' compensation pool may request an expedited
9 hearing pursuant to this paragraph to determine the issue of
10 coverage, provided coverage is the only issue in dispute and
11 all other issues are stipulated and agreed to and further
12 provided that all compensation benefits including medical
13 benefits pursuant to Section 8(a) of the Workers' Compensation
14 Act continue to be paid to or on behalf of petitioner. Any
15 insurance carrier, private self-insured, or group workers'
16 compensation pool that is determined to be liable for coverage
17 for the disease in issue shall reimburse any insurance
18 carrier, private self-insured, or group workers' compensation
19 pool that has paid benefits to or on behalf of petitioner for
20 the disease.

21 (b-1) If the employee is not receiving, pursuant to
22 Section 7, medical, surgical or hospital services of the type
23 provided for in paragraph (a) of Section 8 of the Workers'
24 Compensation Act or compensation of the type provided for in
25 paragraph (b) of Section 8 of the Workers' Compensation Act,
26 the employee, in accordance with Commission Rules, may file a

1 petition for an emergency hearing by an Arbitrator on the
2 issue of whether or not he is entitled to receive payment of
3 such compensation or services as provided therein. Such
4 petition shall have priority over all other petitions and
5 shall be heard by the Arbitrator and Commission with all
6 convenient speed.

7 Such petition shall contain the following information and
8 shall be served on the employer at least 15 days before it is
9 filed:

10 (i) the date and approximate time of the last
11 exposure;

12 (ii) the approximate location of the last exposure;

13 (iii) a description of the last exposure;

14 (iv) the nature of the disability incurred by the
15 employee;

16 (v) the identity of the person, if known, to whom the
17 disability was reported and the date on which it was
18 reported;

19 (vi) the name and title of the person, if known,
20 representing the employer with whom the employee conferred
21 in any effort to obtain pursuant to Section 7 compensation
22 of the type provided for in paragraph (b) of Section 8 of
23 the Workers' Compensation Act or medical, surgical or
24 hospital services of the type provided for in paragraph
25 (a) of Section 8 of the Workers' Compensation Act and the
26 date of such conference;

1 (vii) a statement that the employer has refused to pay
2 compensation pursuant to Section 7 of the type provided
3 for in paragraph (b) of Section 8 of the Workers'
4 Compensation Act or for medical, surgical or hospital
5 services pursuant to Section 7 of the type provided for in
6 paragraph (a) of Section 8 of the Workers' Compensation
7 Act;

8 (viii) the name and address, if known, of each witness
9 to the last exposure and of each other person upon whom the
10 employee will rely to support his allegations;

11 (ix) the dates of treatment related to the disability
12 by medical practitioners, and the names and addresses of
13 such practitioners, including the dates of treatment
14 related to the disability at any hospitals and the names
15 and addresses of such hospitals, and a signed
16 authorization permitting the employer to examine all
17 medical records of all practitioners and hospitals named
18 pursuant to this paragraph;

19 (x) a copy of a signed report by a medical
20 practitioner, relating to the employee's current inability
21 to return to work because of the disability incurred as a
22 result of the exposure or such other documents or
23 affidavits which show that the employee is entitled to
24 receive pursuant to Section 7 compensation of the type
25 provided for in paragraph (b) of Section 8 of the Workers'
26 Compensation Act or medical, surgical or hospital services

1 of the type provided for in paragraph (a) of Section 8 of
2 the Workers' Compensation Act. Such reports, documents or
3 affidavits shall state, if possible, the history of the
4 exposure given by the employee, and describe the
5 disability and medical diagnosis, the medical services for
6 such disability which the employee has received and is
7 receiving, the physical activities which the employee
8 cannot currently perform as a result of such disability,
9 and the prognosis for recovery;

10 (xi) complete copies of any reports, records,
11 documents and affidavits in the possession of the employee
12 on which the employee will rely to support his
13 allegations, provided that the employer shall pay the
14 reasonable cost of reproduction thereof;

15 (xii) a list of any reports, records, documents and
16 affidavits which the employee has demanded by subpoena and
17 on which he intends to rely to support his allegations;

18 (xiii) a certification signed by the employee or his
19 representative that the employer has received the petition
20 with the required information 15 days before filing.

21 Fifteen days after receipt by the employer of the petition
22 with the required information the employee may file said
23 petition and required information and shall serve notice of
24 the filing upon the employer. The employer may file a motion
25 addressed to the sufficiency of the petition. If an objection
26 has been filed to the sufficiency of the petition, the

1 arbitrator shall rule on the objection within 2 working days.
2 If such an objection is filed, the time for filing the final
3 decision of the Commission as provided in this paragraph shall
4 be tolled until the arbitrator has determined that the
5 petition is sufficient.

6 The employer shall, within 15 days after receipt of the
7 notice that such petition is filed, file with the Commission
8 and serve on the employee or his representative a written
9 response to each claim set forth in the petition, including
10 the legal and factual basis for each disputed allegation and
11 the following information: (i) complete copies of any reports,
12 records, documents and affidavits in the possession of the
13 employer on which the employer intends to rely in support of
14 his response, (ii) a list of any reports, records, documents
15 and affidavits which the employer has demanded by subpoena and
16 on which the employer intends to rely in support of his
17 response, (iii) the name and address of each witness on whom
18 the employer will rely to support his response, and (iv) the
19 names and addresses of any medical practitioners selected by
20 the employer pursuant to Section 12 of this Act and the time
21 and place of any examination scheduled to be made pursuant to
22 such Section.

23 Any employer who does not timely file and serve a written
24 response without good cause may not introduce any evidence to
25 dispute any claim of the employee but may cross examine the
26 employee or any witness brought by the employee and otherwise

1 be heard.

2 No document or other evidence not previously identified by
3 either party with the petition or written response, or by any
4 other means before the hearing, may be introduced into
5 evidence without good cause. If, at the hearing, material
6 information is discovered which was not previously disclosed,
7 the Arbitrator may extend the time for closing proof on the
8 motion of a party for a reasonable period of time which may be
9 more than 30 days. No evidence may be introduced pursuant to
10 this paragraph as to permanent disability. No award may be
11 entered for permanent disability pursuant to this paragraph.
12 Either party may introduce into evidence the testimony taken
13 by deposition of any medical practitioner.

14 The Commission shall adopt rules, regulations and
15 procedures whereby the final decision of the Commission is
16 filed not later than 90 days from the date the petition for
17 review is filed but in no event later than 180 days from the
18 date the petition for an emergency hearing is filed with the
19 Illinois Workers' Compensation Commission.

20 All service required pursuant to this paragraph (b-1) must
21 be by personal service or by certified mail and with evidence
22 of receipt. In addition, for the purposes of this paragraph,
23 all service on the employer must be at the premises where the
24 accident occurred if the premises are owned or operated by the
25 employer. Otherwise service must be at the employee's
26 principal place of employment by the employer. If service on

1 the employer is not possible at either of the above, then
2 service shall be at the employer's principal place of
3 business. After initial service in each case, service shall be
4 made on the employer's attorney or designated representative.

5 (c)(1) At a reasonable time in advance of and in
6 connection with the hearing under Section 19(e) or 19(h), the
7 Commission may on its own motion order an impartial physical
8 or mental examination of a petitioner whose mental or physical
9 condition is in issue, when in the Commission's discretion it
10 appears that such an examination will materially aid in the
11 just determination of the case. The examination shall be made
12 by a member or members of a panel of physicians chosen for
13 their special qualifications by the Illinois State Medical
14 Society. The Commission shall establish procedures by which a
15 physician shall be selected from such list.

16 (2) Should the Commission at any time during the hearing
17 find that compelling considerations make it advisable to have
18 an examination and report at that time, the Commission may in
19 its discretion so order.

20 (3) A copy of the report of examination shall be given to
21 the Commission and to the attorneys for the parties.

22 (4) Either party or the Commission may call the examining
23 physician or physicians to testify. Any physician so called
24 shall be subject to cross-examination.

25 (5) The examination shall be made, and the physician or
26 physicians, if called, shall testify, without cost to the

1 parties. The Commission shall determine the compensation and
2 the pay of the physician or physicians. The compensation for
3 this service shall not exceed the usual and customary amount
4 for such service.

5 The fees and payment thereof of all attorneys and
6 physicians for services authorized by the Commission under
7 this Act shall, upon request of either the employer or the
8 employee or the beneficiary affected, be subject to the review
9 and decision of the Commission.

10 (d) If any employee shall persist in insanitary or
11 injurious practices which tend to either imperil or retard his
12 recovery or shall refuse to submit to such medical, surgical,
13 or hospital treatment as is reasonably essential to promote
14 his recovery, the Commission may, in its discretion, reduce or
15 suspend the compensation of any such employee; provided, that
16 when an employer and employee so agree in writing, the
17 foregoing provision shall not be construed to authorize the
18 reduction or suspension of compensation of an employee who is
19 relying in good faith, on treatment by prayer or spiritual
20 means alone, in accordance with the tenets and practice of a
21 recognized church or religious denomination, by a duly
22 accredited practitioner thereof.

23 (e) This paragraph shall apply to all hearings before the
24 Commission. Such hearings may be held in its office or
25 elsewhere as the Commission may deem advisable. The taking of
26 testimony on such hearings may be had before any member of the

1 Commission. If a petition for review and agreed statement of
2 facts or transcript of evidence is filed, as provided herein,
3 the Commission shall promptly review the decision of the
4 Arbitrator and all questions of law or fact which appear from
5 the statement of facts or transcripts of evidence. In all
6 cases in which the hearing before the arbitrator is held after
7 the effective date of this amendatory Act of 1989, no
8 additional evidence shall be introduced by the parties before
9 the Commission on review of the decision of the Arbitrator.
10 The Commission shall file in its office its decision thereon,
11 and shall immediately send to each party or his attorney a copy
12 of such decision and a notification of the time when it was
13 filed. Decisions shall be filed within 60 days after the
14 Statement of Exceptions and Supporting Brief and Response
15 thereto are required to be filed or oral argument whichever is
16 later.

17 In the event either party requests oral argument, such
18 argument shall be had before a panel of 3 members of the
19 Commission (or before all available members pursuant to the
20 determination of 7 members of the Commission that such
21 argument be held before all available members of the
22 Commission) pursuant to the rules and regulations of the
23 Commission. A panel of 3 members, which shall be comprised of
24 not more than one representative citizen of the employing
25 class and not more than one representative from a labor
26 organization recognized under the National Labor Relations Act

1 or an attorney who has represented labor organizations or has
2 represented employees in workers' compensation cases, shall
3 hear the argument; provided that if all the issues in dispute
4 are solely the nature and extent of the permanent partial
5 disability, if any, a majority of the panel may deny the
6 request for such argument and such argument shall not be held;
7 and provided further that 7 members of the Commission may
8 determine that the argument be held before all available
9 members of the Commission. A decision of the Commission shall
10 be approved by a majority of Commissioners present at such
11 hearing if any; provided, if no such hearing is held, a
12 decision of the Commission shall be approved by a majority of a
13 panel of 3 members of the Commission as described in this
14 Section. The Commission shall give 10 days' notice to the
15 parties or their attorneys of the time and place of such taking
16 of testimony and of such argument.

17 In any case the Commission in its decision may in its
18 discretion find specially upon any question or questions of
19 law or facts which shall be submitted in writing by either
20 party whether ultimate or otherwise; provided that on issues
21 other than nature and extent of the disablement, if any, the
22 Commission in its decision shall find specially upon any
23 question or questions of law or fact, whether ultimate or
24 otherwise, which are submitted in writing by either party;
25 provided further that not more than 5 such questions may be
26 submitted by either party. Any party may, within 20 days after

1 receipt of notice of the Commission's decision, or within such
2 further time, not exceeding 30 days, as the Commission may
3 grant, file with the Commission either an agreed statement of
4 the facts appearing upon the hearing, or, if such party shall
5 so elect, a correct transcript of evidence of the additional
6 proceedings presented before the Commission in which report
7 the party may embody a correct statement of such other
8 proceedings in the case as such party may desire to have
9 reviewed, such statement of facts or transcript of evidence to
10 be authenticated by the signature of the parties or their
11 attorneys, and in the event that they do not agree, then the
12 authentication of such transcript of evidence shall be by the
13 signature of any member of the Commission.

14 If a reporter does not for any reason furnish a transcript
15 of the proceedings before the Arbitrator in any case for use on
16 a hearing for review before the Commission, within the
17 limitations of time as fixed in this Section, the Commission
18 may, in its discretion, order a trial de novo before the
19 Commission in such case upon application of either party. The
20 applications for adjustment of claim and other documents in
21 the nature of pleadings filed by either party, together with
22 the decisions of the Arbitrator and of the Commission and the
23 statement of facts or transcript of evidence hereinbefore
24 provided for in paragraphs (b) and (c) shall be the record of
25 the proceedings of the Commission, and shall be subject to
26 review as hereinafter provided.

1 At the request of either party or on its own motion, the
2 Commission shall set forth in writing the reasons for the
3 decision, including findings of fact and conclusions of law,
4 separately stated. The Commission shall by rule adopt a format
5 for written decisions for the Commission and arbitrators. The
6 written decisions shall be concise and shall succinctly state
7 the facts and reasons for the decision. The Commission may
8 adopt in whole or in part, the decision of the arbitrator as
9 the decision of the Commission. When the Commission does so
10 adopt the decision of the arbitrator, it shall do so by order.
11 Whenever the Commission adopts part of the arbitrator's
12 decision, but not all, it shall include in the order the
13 reasons for not adopting all of the arbitrator's decision.
14 When a majority of a panel, after deliberation, has arrived at
15 its decision, the decision shall be filed as provided in this
16 Section without unnecessary delay, and without regard to the
17 fact that a member of the panel has expressed an intention to
18 dissent. Any member of the panel may file a dissent. Any
19 dissent shall be filed no later than 10 days after the decision
20 of the majority has been filed.

21 Decisions rendered by the Commission after the effective
22 date of this amendatory Act of 1980 and dissents, if any, shall
23 be published together by the Commission. The conclusions of
24 law set out in such decisions shall be regarded as precedents
25 by arbitrators, for the purpose of achieving a more uniform
26 administration of this Act.

1 (f) The decision of the Commission acting within its
2 powers, according to the provisions of paragraph (e) of this
3 Section shall, in the absence of fraud, be conclusive unless
4 reviewed as in this paragraph hereinafter provided. However,
5 the Arbitrator or the Commission may on his or its own motion,
6 or on the motion of either party, correct any clerical error or
7 errors in computation within 15 days after the date of receipt
8 of any award by such Arbitrator or any decision on review of
9 the Commission, and shall have the power to recall the
10 original award on arbitration or decision on review, and issue
11 in lieu thereof such corrected award or decision. Where such
12 correction is made the time for review herein specified shall
13 begin to run from the date of the receipt of the corrected
14 award or decision.

15 (1) Except in cases of claims against the State of
16 Illinois, in which case the decision of the Commission
17 shall not be subject to judicial review, the Circuit Court
18 of the county where any of the parties defendant may be
19 found, or if none of the parties defendant be found in this
20 State then the Circuit Court of the county where any of the
21 exposure occurred, shall by summons to the Commission have
22 power to review all questions of law and fact presented by
23 such record.

24 A proceeding for review shall be commenced within 20
25 days of the receipt of notice of the decision of the
26 Commission. The summons shall be issued by the clerk of

1 such court upon written request returnable on a designated
2 return day, not less than 10 or more than 60 days from the
3 date of issuance thereof, and the written request shall
4 contain the last known address of other parties in
5 interest and their attorneys of record who are to be
6 served by summons. Service upon any member of the
7 Commission or the Secretary or the Assistant Secretary
8 thereof shall be service upon the Commission, and service
9 upon other parties in interest and their attorneys of
10 record shall be by summons, and such service shall be made
11 upon the Commission and other parties in interest by
12 mailing notices of the commencement of the proceedings and
13 the return day of the summons to the office of the
14 Commission and to the last known place of residence of
15 other parties in interest or their attorney or attorneys
16 of record. The clerk of the court issuing the summons
17 shall on the day of issue mail notice of the commencement
18 of the proceedings which shall be done by mailing a copy of
19 the summons to the office of the Commission, and a copy of
20 the summons to the other parties in interest or their
21 attorney or attorneys of record and the clerk of the court
22 shall make certificate that he has so sent such notices in
23 pursuance of this Section, which shall be evidence of
24 service on the Commission and other parties in interest.

25 The Commission shall not be required to certify the
26 record of their proceedings in the Circuit Court unless

1 the party commencing the proceedings for review in the
2 Circuit Court as above provided, shall file with the
3 Commission notice of intent to file for review in Circuit
4 Court. It shall be the duty of the Commission upon such
5 filing of notice of intent to file for review in Circuit
6 Court to prepare a true and correct copy of such testimony
7 and a true and correct copy of all other matters contained
8 in such record and certified to by the Secretary or
9 Assistant Secretary thereof. The changes made to this
10 subdivision (f)(1) by this amendatory Act of the 98th
11 General Assembly apply to any Commission decision entered
12 after the effective date of this amendatory Act of the
13 98th General Assembly.

14 No request for a summons may be filed and no summons
15 shall issue unless the party seeking to review the
16 decision of the Commission shall exhibit to the clerk of
17 the Circuit Court proof of filing with the Commission of
18 the notice of the intent to file for review in the Circuit
19 Court or an affidavit of the attorney setting forth that
20 notice of intent to file for review in Circuit Court has
21 been given in writing to the Secretary or Assistant
22 Secretary of the Commission.

23 (2) No such summons shall issue unless the one against
24 whom the Commission shall have rendered an award for the
25 payment of money shall upon the filing of his written
26 request for such summons file with the clerk of the court a

1 bond conditioned that if he shall not successfully
2 prosecute the review, he will pay the award and the costs
3 of the proceedings in the court. The amount of the bond
4 shall be fixed by any member of the Commission and the
5 surety or sureties of the bond shall be approved by the
6 clerk of the court. The acceptance of the bond by the clerk
7 of the court shall constitute evidence of his approval of
8 the bond.

9 The following ~~Every county, city, town, township,~~
10 ~~incorporated village, school district, body politic or~~
11 ~~municipal corporation having a population of 500,000 or~~
12 ~~more against whom the Commission shall have rendered an~~
13 ~~award for the payment of money shall not be required to~~
14 file a bond to secure the payment of the award and the
15 costs of the proceedings in the court to authorize the
16 court to issue such summons:—

17 (1) the State Treasurer, for a fund administered
18 by the State Treasurer ex officio against whom the
19 Commission shall have rendered an award for the
20 payment of money; and

21 (2) a county, city, town, township, incorporated
22 village, school district, body politic, or municipal
23 corporation having a population of 500,000 or more
24 against whom the Commission shall have rendered an
25 award for the payment of money.

26 The court may confirm or set aside the decision of the

1 Commission. If the decision is set aside and the facts
2 found in the proceedings before the Commission are
3 sufficient, the court may enter such decision as is
4 justified by law, or may remand the cause to the
5 Commission for further proceedings and may state the
6 questions requiring further hearing, and give such other
7 instructions as may be proper. Appeals shall be taken to
8 the Appellate Court in accordance with Supreme Court Rules
9 22(g) and 303. Appeals shall be taken from the Appellate
10 Court to the Supreme Court in accordance with Supreme
11 Court Rule 315.

12 It shall be the duty of the clerk of any court
13 rendering a decision affecting or affirming an award of
14 the Commission to promptly furnish the Commission with a
15 copy of such decision, without charge.

16 The decision of a majority of the members of the panel
17 of the Commission, shall be considered the decision of the
18 Commission.

19 (g) Except in the case of a claim against the State of
20 Illinois, either party may present a certified copy of the
21 award of the Arbitrator, or a certified copy of the decision of
22 the Commission when the same has become final, when no
23 proceedings for review are pending, providing for the payment
24 of compensation according to this Act, to the Circuit Court of
25 the county in which such exposure occurred or either of the
26 parties are residents, whereupon the court shall enter a

1 judgment in accordance therewith. In case where the employer
2 refuses to pay compensation according to such final award or
3 such final decision upon which such judgment is entered, the
4 court shall in entering judgment thereon, tax as costs against
5 him the reasonable costs and attorney fees in the arbitration
6 proceedings and in the court entering the judgment for the
7 person in whose favor the judgment is entered, which judgment
8 and costs taxed as herein provided shall, until and unless set
9 aside, have the same effect as though duly entered in an action
10 duly tried and determined by the court, and shall with like
11 effect, be entered and docketed. The Circuit Court shall have
12 power at any time upon application to make any such judgment
13 conform to any modification required by any subsequent
14 decision of the Supreme Court upon appeal, or as the result of
15 any subsequent proceedings for review, as provided in this
16 Act.

17 Judgment shall not be entered until 15 days' notice of the
18 time and place of the application for the entry of judgment
19 shall be served upon the employer by filing such notice with
20 the Commission, which Commission shall, in case it has on file
21 the address of the employer or the name and address of its
22 agent upon whom notices may be served, immediately send a copy
23 of the notice to the employer or such designated agent.

24 (h) An agreement or award under this Act providing for
25 compensation in installments, may at any time within 18 months
26 after such agreement or award be reviewed by the Commission at

1 the request of either the employer or the employee on the
2 ground that the disability of the employee has subsequently
3 recurred, increased, diminished or ended.

4 However, as to disablements occurring subsequently to July
5 1, 1955, which are covered by any agreement or award under this
6 Act providing for compensation in installments made as a
7 result of such disablement, such agreement or award may at any
8 time within 30 months after such agreement or award be
9 reviewed by the Commission at the request of either the
10 employer or the employee on the ground that the disability of
11 the employee has subsequently recurred, increased, diminished
12 or ended.

13 On such review compensation payments may be
14 re-established, increased, diminished or ended. The Commission
15 shall give 15 days' notice to the parties of the hearing for
16 review. Any employee, upon any petition for such review being
17 filed by the employer, shall be entitled to one day's notice
18 for each 100 miles necessary to be traveled by him in attending
19 the hearing of the Commission upon the petition, and 3 days in
20 addition thereto. Such employee shall, at the discretion of
21 the Commission, also be entitled to 5 cents per mile
22 necessarily traveled by him within the State of Illinois in
23 attending such hearing, not to exceed a distance of 300 miles,
24 to be taxed by the Commission as costs and deposited with the
25 petition of the employer.

26 When compensation which is payable in accordance with an

1 award or settlement contract approved by the Commission, is
2 ordered paid in a lump sum by the Commission, no review shall
3 be had as in this paragraph mentioned.

4 (i) Each party, upon taking any proceedings or steps
5 whatsoever before any Arbitrator, Commission or court, shall
6 file with the Commission his address, or the name and address
7 of any agent upon whom all notices to be given to such party
8 shall be served, either personally or by registered mail,
9 addressed to such party or agent at the last address so filed
10 with the Commission. In the event such party has not filed his
11 address, or the name and address of an agent as above provided,
12 service of any notice may be had by filing such notice with the
13 Commission.

14 (j) Whenever in any proceeding testimony has been taken or
15 a final decision has been rendered, and after the taking of
16 such testimony or after such decision has become final, the
17 employee dies, then in any subsequent proceeding brought by
18 the personal representative or beneficiaries of the deceased
19 employee, such testimony in the former proceeding may be
20 introduced with the same force and effect as though the
21 witness having so testified were present in person in such
22 subsequent proceedings and such final decision, if any, shall
23 be taken as final adjudication of any of the issues which are
24 the same in both proceedings.

25 (k) In any case where there has been any unreasonable or
26 vexatious delay of payment or intentional underpayment of

1 compensation, or proceedings have been instituted or carried
2 on by one liable to pay the compensation, which do not present
3 a real controversy, but are merely frivolous or for delay,
4 then the Commission may award compensation additional to that
5 otherwise payable under this Act equal to 50% of the amount
6 payable at the time of such award. Failure to pay compensation
7 in accordance with the provisions of Section 8, paragraph (b)
8 of this Act, shall be considered unreasonable delay.

9 When determining whether this subsection (k) shall apply,
10 the Commission shall consider whether an arbitrator has
11 determined that the claim is not compensable or whether the
12 employer has made payments under Section 8(j) of the Workers'
13 Compensation Act.

14 (k-1) If the employee has made written demand for payment
15 of benefits under Section 8(a) or Section 8(b) of the Workers'
16 Compensation Act, the employer shall have 14 days after
17 receipt of the demand to set forth in writing the reason for
18 the delay. In the case of demand for payment of medical
19 benefits under Section 8(a) of the Workers' Compensation Act,
20 the time for the employer to respond shall not commence until
21 the expiration of the allotted 60 days specified under Section
22 8.2(d) of the Workers' Compensation Act. In case the employer
23 or his or her insurance carrier shall without good and just
24 cause fail, neglect, refuse, or unreasonably delay the payment
25 of benefits under Section 8(a) or Section 8(b) of the Workers'
26 Compensation Act, the Arbitrator or the Commission shall allow

1 to the employee additional compensation in the sum of \$30 per
2 day for each day that the benefits under Section 8(a) or
3 Section 8(b) of the Workers' Compensation Act have been so
4 withheld or refused, not to exceed \$10,000. A delay in payment
5 of 14 days or more shall create a rebuttable presumption of
6 unreasonable delay.

7 (1) By the 15th day of each month each insurer providing
8 coverage for losses under this Act shall notify each insured
9 employer of any compensable claim incurred during the
10 preceding month and the amounts paid or reserved on the claim
11 including a summary of the claim and a brief statement of the
12 reasons for compensability. A cumulative report of all claims
13 incurred during a calendar year or continued from the previous
14 year shall be furnished to the insured employer by the insurer
15 within 30 days after the end of that calendar year.

16 The insured employer may challenge, in proceeding before
17 the Commission, payments made by the insurer without
18 arbitration and payments made after a case is determined to be
19 noncompensable. If the Commission finds that the case was not
20 compensable, the insurer shall purge its records as to that
21 employer of any loss or expense associated with the claim,
22 reimburse the employer for attorneys fee arising from the
23 challenge and for any payment required of the employer to the
24 Rate Adjustment Fund or the Second Injury Fund, and may not
25 effect the loss or expense for rate making purposes. The
26 employee shall not be required to refund the challenged

1 payment. The decision of the Commission may be reviewed in the
2 same manner as in arbitrated cases. No challenge may be
3 initiated under this paragraph more than 3 years after the
4 payment is made. An employer may waive the right of challenge
5 under this paragraph on a case by case basis.

6 (m) After filing an application for adjustment of claim
7 but prior to the hearing on arbitration the parties may
8 voluntarily agree to submit such application for adjustment of
9 claim for decision by an arbitrator under this subsection (m)
10 where such application for adjustment of claim raises only a
11 dispute over temporary total disability, permanent partial
12 disability or medical expenses. Such agreement shall be in
13 writing in such form as provided by the Commission.
14 Applications for adjustment of claim submitted for decision by
15 an arbitrator under this subsection (m) shall proceed
16 according to rule as established by the Commission. The
17 Commission shall promulgate rules including, but not limited
18 to, rules to ensure that the parties are adequately informed
19 of their rights under this subsection (m) and of the voluntary
20 nature of proceedings under this subsection (m). The findings
21 of fact made by an arbitrator acting within his or her powers
22 under this subsection (m) in the absence of fraud shall be
23 conclusive. However, the arbitrator may on his own motion, or
24 the motion of either party, correct any clerical errors or
25 errors in computation within 15 days after the date of receipt
26 of such award of the arbitrator and shall have the power to

1 recall the original award on arbitration, and issue in lieu
2 thereof such corrected award. The decision of the arbitrator
3 under this subsection (m) shall be considered the decision of
4 the Commission and proceedings for review of questions of law
5 arising from the decision may be commenced by either party
6 pursuant to subsection (f) of Section 19. The Advisory Board
7 established under Section 13.1 of the Workers' Compensation
8 Act shall compile a list of certified Commission arbitrators,
9 each of whom shall be approved by at least 7 members of the
10 Advisory Board. The chairman shall select 5 persons from such
11 list to serve as arbitrators under this subsection (m). By
12 agreement, the parties shall select one arbitrator from among
13 the 5 persons selected by the chairman except, that if the
14 parties do not agree on an arbitrator from among the 5 persons,
15 the parties may, by agreement, select an arbitrator of the
16 American Arbitration Association, whose fee shall be paid by
17 the State in accordance with rules promulgated by the
18 Commission. Arbitration under this subsection (m) shall be
19 voluntary.

20 (Source: P.A. 101-384, eff. 1-1-20.)

21 Section 50. The Unemployment Insurance Act is amended by
22 changing Section 1900 as follows:

23 (820 ILCS 405/1900) (from Ch. 48, par. 640)

24 Sec. 1900. Disclosure of information.

1 A. Except as provided in this Section, information
2 obtained from any individual or employing unit during the
3 administration of this Act shall:

4 1. be confidential,

5 2. not be published or open to public inspection,

6 3. not be used in any court in any pending action or
7 proceeding,

8 4. not be admissible in evidence in any action or
9 proceeding other than one arising out of this Act.

10 B. No finding, determination, decision, ruling, or order
11 (including any finding of fact, statement or conclusion made
12 therein) issued pursuant to this Act shall be admissible or
13 used in evidence in any action other than one arising out of
14 this Act, nor shall it be binding or conclusive except as
15 provided in this Act, nor shall it constitute res judicata,
16 regardless of whether the actions were between the same or
17 related parties or involved the same facts.

18 C. Any officer or employee of this State, any officer or
19 employee of any entity authorized to obtain information
20 pursuant to this Section, and any agent of this State or of
21 such entity who, except with authority of the Director under
22 this Section or as authorized pursuant to subsection P-1,
23 shall disclose information shall be guilty of a Class B
24 misdemeanor and shall be disqualified from holding any
25 appointment or employment by the State.

26 D. An individual or his duly authorized agent may be

1 supplied with information from records only to the extent
2 necessary for the proper presentation of his claim for
3 benefits or with his existing or prospective rights to
4 benefits. Discretion to disclose this information belongs
5 solely to the Director and is not subject to a release or
6 waiver by the individual. Notwithstanding any other provision
7 to the contrary, an individual or his or her duly authorized
8 agent may be supplied with a statement of the amount of
9 benefits paid to the individual during the 18 months preceding
10 the date of his or her request.

11 E. An employing unit may be furnished with information,
12 only if deemed by the Director as necessary to enable it to
13 fully discharge its obligations or safeguard its rights under
14 the Act. Discretion to disclose this information belongs
15 solely to the Director and is not subject to a release or
16 waiver by the employing unit.

17 F. The Director may furnish any information that he may
18 deem proper to any public officer or public agency of this or
19 any other State or of the federal government dealing with:

- 20 1. the administration of relief,
- 21 2. public assistance,
- 22 3. unemployment compensation,
- 23 4. a system of public employment offices,
- 24 5. wages and hours of employment, or
- 25 6. a public works program.

26 The Director may make available to the Illinois Workers'

1 Compensation Commission or the Department of Insurance
2 information regarding employers for the purpose of verifying
3 the insurance coverage required under the Workers'
4 Compensation Act and Workers' Occupational Diseases Act.

5 G. The Director may disclose information submitted by the
6 State or any of its political subdivisions, municipal
7 corporations, instrumentalities, or school or community
8 college districts, except for information which specifically
9 identifies an individual claimant.

10 H. The Director shall disclose only that information
11 required to be disclosed under Section 303 of the Social
12 Security Act, as amended, including:

13 1. any information required to be given the United
14 States Department of Labor under Section 303(a) (6); and

15 2. the making available upon request to any agency of
16 the United States charged with the administration of
17 public works or assistance through public employment, the
18 name, address, ordinary occupation, and employment status
19 of each recipient of unemployment compensation, and a
20 statement of such recipient's right to further
21 compensation under such law as required by Section
22 303(a) (7); and

23 3. records to make available to the Railroad
24 Retirement Board as required by Section 303(c) (1); and

25 4. information that will assure reasonable cooperation
26 with every agency of the United States charged with the

1 administration of any unemployment compensation law as
2 required by Section 303(c)(2); and

3 5. information upon request and on a reimbursable
4 basis to the United States Department of Agriculture and
5 to any State food stamp agency concerning any information
6 required to be furnished by Section 303(d); and

7 6. any wage information upon request and on a
8 reimbursable basis to any State or local child support
9 enforcement agency required by Section 303(e); and

10 7. any information required under the income
11 eligibility and verification system as required by Section
12 303(f); and

13 8. information that might be useful in locating an
14 absent parent or that parent's employer, establishing
15 paternity or establishing, modifying, or enforcing child
16 support orders for the purpose of a child support
17 enforcement program under Title IV of the Social Security
18 Act upon the request of and on a reimbursable basis to the
19 public agency administering the Federal Parent Locator
20 Service as required by Section 303(h); and

21 9. information, upon request, to representatives of
22 any federal, State, or local governmental public housing
23 agency with respect to individuals who have signed the
24 appropriate consent form approved by the Secretary of
25 Housing and Urban Development and who are applying for or
26 participating in any housing assistance program

1 administered by the United States Department of Housing
2 and Urban Development as required by Section 303(i).

3 I. The Director, upon the request of a public agency of
4 Illinois, of the federal government, or of any other state
5 charged with the investigation or enforcement of Section 10-5
6 of the Criminal Code of 2012 (or a similar federal law or
7 similar law of another State), may furnish the public agency
8 information regarding the individual specified in the request
9 as to:

10 1. the current or most recent home address of the
11 individual, and

12 2. the names and addresses of the individual's
13 employers.

14 J. Nothing in this Section shall be deemed to interfere
15 with the disclosure of certain records as provided for in
16 Section 1706 or with the right to make available to the
17 Internal Revenue Service of the United States Department of
18 the Treasury, or the Department of Revenue of the State of
19 Illinois, information obtained under this Act. With respect to
20 each benefit claim that appears to have been filed other than
21 by the individual in whose name the claim was filed or by the
22 individual's authorized agent and with respect to which
23 benefits were paid during the prior calendar year, the
24 Director shall annually report to the Department of Revenue
25 information that is in the Director's possession and may
26 assist in avoiding negative income tax consequences for the

1 individual in whose name the claim was filed.

2 K. The Department shall make available to the Illinois
3 Student Assistance Commission, upon request, information in
4 the possession of the Department that may be necessary or
5 useful to the Commission in the collection of defaulted or
6 delinquent student loans which the Commission administers.

7 L. The Department shall make available to the State
8 Employees' Retirement System, the State Universities
9 Retirement System, the Teachers' Retirement System of the
10 State of Illinois, and the Department of Central Management
11 Services, Risk Management Division, upon request, information
12 in the possession of the Department that may be necessary or
13 useful to the System or the Risk Management Division for the
14 purpose of determining whether any recipient of a disability
15 benefit from the System or a workers' compensation benefit
16 from the Risk Management Division is gainfully employed.

17 M. This Section shall be applicable to the information
18 obtained in the administration of the State employment
19 service, except that the Director may publish or release
20 general labor market information and may furnish information
21 that he may deem proper to an individual, public officer, or
22 public agency of this or any other State or the federal
23 government (in addition to those public officers or public
24 agencies specified in this Section) as he prescribes by Rule.

25 N. The Director may require such safeguards as he deems
26 proper to insure that information disclosed pursuant to this

1 Section is used only for the purposes set forth in this
2 Section.

3 O. Nothing in this Section prohibits communication with an
4 individual or entity through unencrypted e-mail or other
5 unencrypted electronic means as long as the communication does
6 not contain the individual's or entity's name in combination
7 with any one or more of the individual's or entity's entire or
8 partial social security number; driver's license or State
9 identification number; credit or debit card number; or any
10 required security code, access code, or password that would
11 permit access to further information pertaining to the
12 individual or entity.

13 P. (Blank).

14 P-1. With the express written consent of a claimant or
15 employing unit and an agreement not to publicly disclose, the
16 Director shall provide requested information related to a
17 claim to an elected official performing constituent services
18 or his or her agent.

19 Q. The Director shall make available to an elected federal
20 official the name and address of an individual or entity that
21 is located within the jurisdiction from which the official was
22 elected and that, for the most recently completed calendar
23 year, has reported to the Department as paying wages to
24 workers, where the information will be used in connection with
25 the official duties of the official and the official requests
26 the information in writing, specifying the purposes for which

1 it will be used. For purposes of this subsection, the use of
2 information in connection with the official duties of an
3 official does not include use of the information in connection
4 with the solicitation of contributions or expenditures, in
5 money or in kind, to or on behalf of a candidate for public or
6 political office or a political party or with respect to a
7 public question, as defined in Section 1-3 of the Election
8 Code, or in connection with any commercial solicitation. Any
9 elected federal official who, in submitting a request for
10 information covered by this subsection, knowingly makes a
11 false statement or fails to disclose a material fact, with the
12 intent to obtain the information for a purpose not authorized
13 by this subsection, shall be guilty of a Class B misdemeanor.

14 R. The Director may provide to any State or local child
15 support agency, upon request and on a reimbursable basis,
16 information that might be useful in locating an absent parent
17 or that parent's employer, establishing paternity, or
18 establishing, modifying, or enforcing child support orders.

19 S. The Department shall make available to a State's
20 Attorney of this State or a State's Attorney's investigator,
21 upon request, the current address or, if the current address
22 is unavailable, current employer information, if available, of
23 a victim of a felony or a witness to a felony or a person
24 against whom an arrest warrant is outstanding.

25 T. The Director shall make available to the Illinois State
26 Police, a county sheriff's office, or a municipal police

1 department, upon request, any information concerning the
2 current address and place of employment or former places of
3 employment of a person who is required to register as a sex
4 offender under the Sex Offender Registration Act that may be
5 useful in enforcing the registration provisions of that Act.

6 U. The Director shall make information available to the
7 Department of Healthcare and Family Services and the
8 Department of Human Services for the purpose of determining
9 eligibility for public benefit programs authorized under the
10 Illinois Public Aid Code and related statutes administered by
11 those departments, for verifying sources and amounts of
12 income, and for other purposes directly connected with the
13 administration of those programs.

14 V. The Director shall make information available to the
15 State Board of Elections as may be required by an agreement the
16 State Board of Elections has entered into with a multi-state
17 voter registration list maintenance system.

18 W. The Director shall make information available to the
19 State Treasurer's office and the Department of Revenue for the
20 purpose of facilitating compliance with the Illinois Secure
21 Choice Savings Program Act, including employer contact
22 information for employers with 25 or more employees and any
23 other information the Director deems appropriate that is
24 directly related to the administration of this program.

25 X. The Director shall make information available, upon
26 request, to the Illinois Student Assistance Commission for the

1 purpose of determining eligibility for the adult vocational
2 community college scholarship program under Section 65.105 of
3 the Higher Education Student Assistance Act.

4 Y. Except as required under State or federal law, or
5 unless otherwise provided for in this Section, the Department
6 shall not disclose an individual's entire social security
7 number in any correspondence physically mailed to an
8 individual or entity.

9 (Source: P.A. 101-315, eff. 1-1-20; 102-26, eff. 6-25-21;
10 102-538, eff. 8-20-21; revised 11-8-21.)

11 Section 99. Effective date. This Act takes effect upon
12 becoming law."